

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 413 MARYLAND STATE DEPARTMENT OF HEALTH
b-9-69 emg DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06995

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06991

1. DECEASED-NAME (Type or Print) First Middle Last Kenneth Alan Abramson			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 5 11 69			2b. HOUR 2:58 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 4-3-34	6. AGE (In years last birthday) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 5 Day 11 Year 1969	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Liquor	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 11633 Lockwood Drive		14. FATHER'S NAME First Middle Last Morris Abramson		15. MOTHER'S MAIDEN NAME First Middle Last Lillian Feldstein			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If was given year or dates of service) 1957-1959 678-44-4414		17. INFORMANT Rita Abramson		ADDRESS 11633 Lockwood Dr. S.S. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute thrombosis, left Coronary artery DUE TO, OR AS A CONSEQUENCE OF Coronary artery heart disease (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED May 11, 1969	
EXAMINER'S NAME (Type) BELDEN R. REAP		M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Montgomery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/12/69		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons				25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE [Signature]	
3501 14th St., N.W., Wash., D.C. 20010							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06996										
CERTIFICATE OF DEATH										
06992										
1. DECEASED-NAME (Type or print) Lillian W. R. Ackley					2a. DATE OF DEATH Month MAY Day 3 Year 1969					
3. SEX Female					4. RACE white		5. DATE OF BIRTH 3-8-1885		6. AGE (In years last birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Kensington, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens 3000 McComas Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION		
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) 2020 F St. NW Washington D.C.			13c. CITY OR TOWN D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2020 F St., N.W.			
14. FATHER'S NAME First Fred Middle W. Last Chase					15. MOTHER'S MAIDEN NAME First Eva Middle Lillian Last Rhodes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 532-10-3198		17. INFORMANT B. J. Binalley, RN - 3000 McComas Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN TUMOR, RT. HEMISPHERE, DUE TO, OR AS A CONSEQUENCE OF (c) UNIDENTIFIED									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 5 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from MAR. 24, 1969 , to MAY 3, 1969 , that (I) (we) last saw the deceased alive on MAY 2, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert G. Angle M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED MAY 3, 1969					
22d. PHYSICIAN'S NAME (Type) Robert G. Angle					22e. ADDRESS 5009 Del Ray Avenue, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5-5-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co., MD				
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016					25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Volunteer, J. G. Jones			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) James ARTHUR Adams						2a. DATE OF DEATH 5 Month 18 Day '69 Year			2b. HOUR 12 P.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-29-89			6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS - DAYS -		IF UNDER 24 HRS. HOURS - MIN -
7a. BIRTHPLACE (State or foreign country) Adams, Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursh.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Attorney-Internal Revenue Ser.			12b. KIND OF BUSINESS OR INDUSTRY NW.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington		13b. COUNTY D.C.		13c. CITY OR TOWN -		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2939 Van Ness St NW			
14. FATHER'S NAME First Redding Middle Columbus Last Adams				15. MOTHER'S MAIDEN NAME First DORA Middle E. Last Stainback							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES W.W.I		16b. SOCIAL SECURITY NO. 578-56-1237		17. INFORMANT George F. Adams Address 4740 Conn. Ave. N.W. Wash. DC							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Monocystic Apathetic Anemia - Hospital 284X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 Months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bilateral Pulmonary Infarcts (b) Coronary arteriosclerosis											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from April , 19 65 , to May , 19 69 , that (I) (we) last saw the deceased alive on 17 May , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. Roger Kurtz, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-18-69					
22d. PHYSICIAN'S NAME (Type) C. Roger Kurtz, M.D.		22e. ADDRESS 370 Church Ave. NW Wash D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/21/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.				
24. FUNERAL DIRECTOR The S. H. Hines Co.				ADDRESS Washington, D. C.		25a. REC'D BY REGISTRAR MAY 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 06998 CERTIFICATE OF DEATH 06994 </div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Elizabeth			nmn Andes			5 Month 14 Day 69 Year			11 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		16 UNDER 1 YEAR
Female		Caus.		12/15/1887			81 YRS.		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Mills, N.Y.		U.S.A.					Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Wheaton			University Nursing Home			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
New York			Utica			YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
								1232 Kimble Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
David			Allerdice			Elizabeth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			057-28-4415-D			David D. Andes (Son)			-4505 Randon-Beltsville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>									10 min
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M.							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-28-</u> , 19 <u>67</u> , to <u>5-14-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-14-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Myron Lenkin								22c. DATE SIGNED	
								5-14-69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
MYRON LENKIN									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Removal		May 14, 1969		New Forest Cemetery			Utica, New York		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silver Spring, Maryland						MAY 15 1969		Charles Judge	
Enver E. Pumphrey, Inc., 8434 Georgia Avenue									

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10, 11, 18 & 22a
Film 413 6-1-18 & 22a
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06999

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06995

1. DECEASED-NAME (Type or Print) Frederick Walter Arbogast			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 5 Day 16 Year 1969			2b. HOUR 2:45 M PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7-14-04	6. AGE (In years last birthday) 64 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 5 Day 16 Year 1969		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. Retired Grocer		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY Self-empld.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Langley Pk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1414 Kanawaha /St
14. FATHER'S NAME First Samuel Middle Arbogast Last Arbogast			15. MOTHER'S MAIDEN NAME First Estelle Middle Simmons Last Simmons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO. yes			17. INFORMANT Lucy M. Arbogast-wife-1414 Kanawaha Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State 				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Belden R. Reap		22b. DATE SIGNED MAY 16, 1969		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		ADDRESS (Street, City, County, State) 8434 Ga. Ave. Sil. Spg. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) Silver Spring, Maryland (County) (State) 		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. ADDRESS 8434 Ga. Ave. Sil. Spg. Md.				25a. REC'D BY REGISTRAR MAY 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

2006

— *Journal of the American Medical Association*

1999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

- Dr. John Bell notified & signed

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
<div>07000</div> <div>CERTIFICATE OF DEATH</div>																				
1 DECEASED-NAME (Type or print)			First BESS			Middle FURMAN			Lost ARMSTRONG			2a. DATE OF DEATH Month MAY Day 12 , Year 1969			2b HOUR 8 A.M.					
3 SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH Dec. 2, 1894			6. AGE (In years lost birthday) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN					
7a BIRTHPLACE (State or foreign country) Nebraska			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			Md								
10 CITY OR TOWN OF DEATH Wood Acres			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5904 Cobalt Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Writer-N.Y. Times			12b. KIND OF BUSINESS OR INDUSTRY Newspaper											
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Montg.			13c CITY OR TOWN Wood Acres			13d INS OF CITY LIMTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 5904 Cobalt Road								
14. FATHER'S NAME First Archie			Middle --			Lost Furman			15 MOTHER'S MAIDEN NAME First Mattie			Middle --			Lost Van Pelt					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give war or dates of service) ---			16b SOCIAL SECURITY NO 577-10-6549			17 INFORMANT Robert F. Armstrong, 6129-12th Rd. N., Arl., Va.			Address								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4709 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 10 min.																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Metastasis																				
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from October, 1961 , to May 7, 1969 , that (I) (we) last saw the deceased alive on May 7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b SIGNATURE George A. Boivis M.D.												DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 5-12-69		
22d PHYSICIAN'S NAME (Type) George A. Boivis												22e ADDRESS 5410 Connecticut Ave NW								
23a BURIAL CREMATION, REMOVAL (Specify) Burial			23b DATE 5/15/69			23c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D.C.											
24 FUNERAL DIRECTOR Joseph Gawler & Sons, 5130 Wisconsin Ave, NW Washington, D.C.												25a REC'D BY REGISTRAR DATE MAY 20 1969			25b REGISTRAR'S SIGNATURE James J. Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07001		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH				06997			
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR				
Betsey R. Arns						May 7 1969			7 AM				
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS		
Female		Caucasian		July 21, 1885			83 YRS.						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
New York State		U.S.A.				Montgomery Md							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Kensington			Carroll Hall Sanitarium			Ret. Investigator			Met. Police				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER				
Maryland			Montgomery		Takoma Park				509 Philadelphia Ave.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Edward A. Riddle						Jenny Abel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address				
No			577-01-6728A			daughter			509 Philadelphia Ave. Takoma Park, Md.				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>central arterio-sclerosis</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>diabetes mellitus</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 68</u> , to <u>May 7, 1969</u> , that (II) (we) lost the deceased on <u>May 7, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
[Signature]			May 7, 1969			Lewis S. Miller, D.M.D.			8916 Bullock Rd. S.S. Md.				
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
[Signature]			May 8, 1969			Grove Cemetery			Towansburg, New York				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. ADDRESS				
Paul J. Smith			MAY 12 1969			[Signature]			8434 Georgia Avenue, Silver Spring, Maryland				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH
5-22-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07002

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06998

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b HOUR															
Joseph						Athey		5-1		1969		6:05		A																	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR MONTHS DAYS		H UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD		Month		Day		Year		2d HOUR													
Male	Wh.	2-11-11		58 YRS						5		1		1969		6:05		A													
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH												Md													
Md.		US				Montgomery																									
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)				12b KIND OF BUSINESS OR INDUSTRY																			
Takoma Park				Washington San & Hosp.				carpenter				construction																			
13a USUA. RESIDENCE (Where deceased lived, if institution admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY - M.T.S?				13e STREET AND NUMBER															
Md.				Pr. Geo. Laurel				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Brooklyn Bridge Rd.																			
14. FATHER'S NAME				First				Middle				Last				15. MOTHER'S MAIDEN NAME				First				Middle				Last			
Benjamin F.				Athey												Mayr				Elizabeth M.				Athey							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS																			
NO								Mr. Roy J. Athey (brother)																							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Acute coronary insufficiency																															
492x DUE TO, OR AS A CONSEQUENCE OF																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																															
(b) due to marked pulmonary emphysema																															
DUE TO, OR AS A CONSEQUENCE OF																															
(c)																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																															
MEDICAL CERTIFICATION																															
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH								21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19								21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)								21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																															
ACTUAL SIGNATURE								CHIEF MEDICAL EXAMINER <input type="checkbox"/>								22b. DATE SIGNED															
EXAMINER'S NAME (Type)								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								MAY 1, 1969															
Belden R. Reap M.D.								23a. REC'D BY REGISTRAR								25b. REGISTRAR'S SIGNATURE															
23a. BURIAL, CREMATION or other (Specify)								23b. DATE								23c. NAME OF CEMETERY OR CREMATORY								23d. LOCATION (City or Town) (County) (State)							
Burial								5-4-69								Union Cem.								Baltimore Md.							
24. FUNERAL DIRECTOR								ADDRESS								25a. DATE								25b. REGISTRAR'S SIGNATURE							
Wanda Drew Funeral Home								Laurel Md.								MAY 6 1969								William J. Jones							

07003

CERTIFICATE OF DEATH

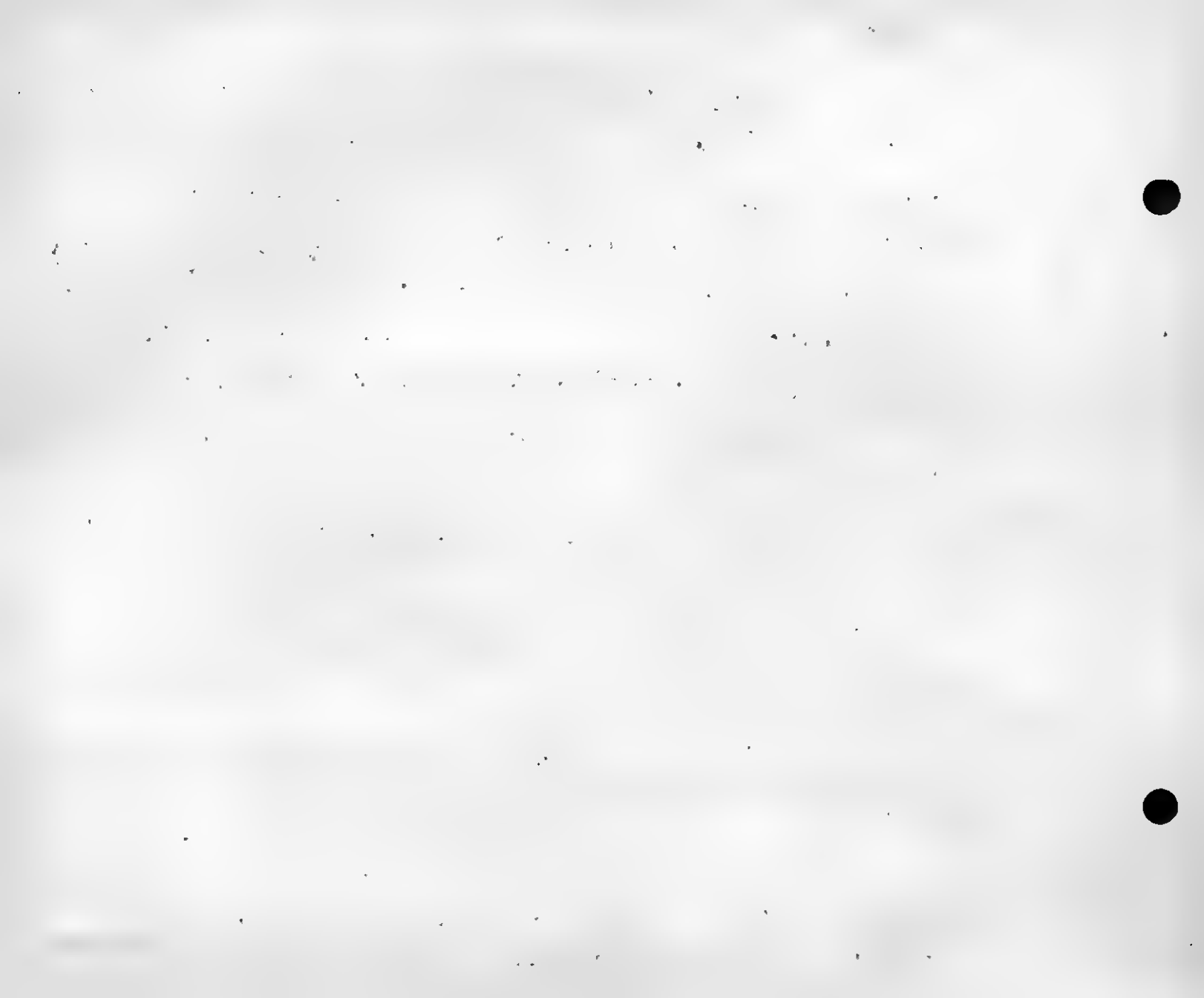
06999

1 DECEASED NAME (Type or print) ELIZABETH LANDON BAMBER			2a DATE OF DEATH Month 5 Day 30 Year 69			2b HOUR 430P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8 August 1901		6 AGE (In years lost birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.				
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) 6015 Woodacres Dr.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Montgomery			13c CITY OR TOWN Bethesda			13d. INSIDE CITY LIM TST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 6015 Woodacres Drive			14 FATHER'S NAME First Middle Last William Henry Landon			15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth B. Finkler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 579-58-3533			17 INFORMANT Address Millard B. KKK BAMBER above address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Carcinoma of Breast (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 4 mos. 4 years		
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/27 , 19 68 , to 5/30 , 19 69 , that (I) (we) last saw the deceased alive on 5/27 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE Frank Y. Jagers Jr. M.D.					22c. DATE SIGNED 5/30/69		22d. PHYSICIAN'S NAME (Type) FRANK Y. JAGERS JR.			
22e. ADDRESS 5707 WISCONSIN AVE Chevy Chase										
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE 6/2/69		23c. NAME OF CEMETERY OR CREMATORY Parklawn cemetery			23d. LOCATION (City or Town) (County) (State) Hampton, Virginia			
24 FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Md.					25a. REC'D BY REGISTRAR DATE JUN 3 1969		25b. REGISTRAR'S SIGNATURE James Judge			

174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

07004

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07000

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH				2b. HOUR	
WILLIAM RUSSELL BARKER						Month Day Year				5 3 19 69 10 55	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	2/13/80	89s	MONTHS	DAYS	HOURS	MIN	Month Day Year		5 3 19 69 10 55	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		A Md.		
Hanover County			USA				Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			paper hanger					
13a. USUA. RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Mont.			SS			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO		
William N. Barker			Virginia H. Gibson			No			228-10-4793		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
niece June Pliss			1107 Arcola Ave. Whet.			Acute Coronary Insufficiency					
						(b) Arteriosclerotic Heart Disease					
						(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M.								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			Belden R. Neap M.D.						MAY 3, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			May 6, 1969			Hollywood Cemetery			Richmond, Virginia		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Paul Smith, Warner E. Pumphrey, Inc., 8434 Georgia Avenue			MAY 7 1969			Richard L. Neap					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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4101
cleared 2:40 coroner

07005

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07001

1 DECEASED NAME (Type or print) Charles M. BEALES			2a DATE OF DEATH Month MAY Day 26 Year 1969			2b. HOUR 7:50 PM	
3. SEX Male		4 RACE Wh.		5 DATE OF BIRTH 10/17/17		6 AGE (in years last birthday) 51 YRS	
7a BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Silver Spring Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) T.V. Repair		12b. KIND OF BUSINESS OR INDUSTRY T.V. Repair	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c CITY OR TOWN Hyattsville		13d INS. OF CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13e STREET AND NUMBER 5023- 59th Avenue		14 FATHER'S NAME First Charles Middle F. Last Beales		15. MOTHER'S MAIDEN NAME First Mamie Middle Duyer Last Duyer			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) WWII		16b SOCIAL SECURITY NO. 577-05-3478		17 INFORMANT Address Rosemary Beales - above address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4101 DUE TO, OR AS A CONSEQUENCE OF (b) Intermittent Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/26/69 , 1969, to 6/26 , 1969, that (I) (we) last saw the deceased alive on 5/26 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harold W. Draper M.D.				22c. DATE SIGNED 5/26/69			
22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER				22e. ADDRESS 9801 GEORGIA AVE, Silver Spring, Md			
23a. BURIAL, CREMATION, REINBURSEMENT Funeral Society		23b. DATE 5/29/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City or Town) (County) (State) Wash., D.C.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25a. REC'D BY REGISTRAR DAVID		25b. REGISTRAR'S SIGNATURE Charles Judge	

Week	Subject	Lesson	Method
2 nd	Algebra	1	20 min. 100%

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07002	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
MARY GENE Beckwith						DATE ESTIMATED 5 26 1969			12 30 A.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	July 17, 1927	41 YRS	MONTHS	DAYS	HOURS	MIN	May 26	1969	12 30 A.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
Pennsylvania		USA				Montgomery					
10. CITY OR TOWN OF DEATH			NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12a KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban			Housewife			Own Home		
3a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b CITY OR TOWN			3d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
VA			Alexandria ALEXANDRIA			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			801 Summit Ave.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S M A D E N NAME First Middle Last								
Pernell Woltz			Cresence HASKER								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS					
No						Roland A. Beckwith Same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage, spontaneous, left basal ganglia area										10 hours	
Cond it ions, if any, which gave rise to immediate cause (a), stating the underlying cause last										years	
(b) Cerebral arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from											
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John S. Ball M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			May 26, 1969		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			5/30/69		West Hill Cemetery			Galeton Potter Pa.			
24 FUNERAL DIRECTOR ADDRESS						25a RECEIVED BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Maryland						JUN 2 1969		Francis Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
07007		CERTIFICATE OF DEATH						07003					
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR		
MICHAEL			A.		BEDARD				MAR 31 1969		2 P M		
3. SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		9/24/41				27 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
CANADA		CANADA				MONTGOMERY		Md					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA				SHARON				DRY WALL MAN				K.H. Const. Co.	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND				MONTGOMERY		ROCKVILLE				4602 BRUNNE COURT			
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last	
Albert							Bedard		Marie			Anne Lafond	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT Address					
No								Louissette Bedard Same as item #13a					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiovascular failure</u> sec													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>not of Malignant Mesothelioma (mesothelioma)</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION			19b CONDIT.ON FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5-4, 19 69 to 5-31, 19 69 that (I) (we) last saw the deceased alive on 5-31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE V.C. de Guzman								22c. DATE SIGNED					
22d PHYSICIAN'S NAME (Type) V. C. de Guzman								22e ADDRESS 1234 19th NW Wash DC					
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)				
Burial-transit			6/1/69		Villeroy Cem				Villeroy Quebec, Canada				
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md												25 REGISTRAR'S SIGNATURE	
JUN 3 1969													

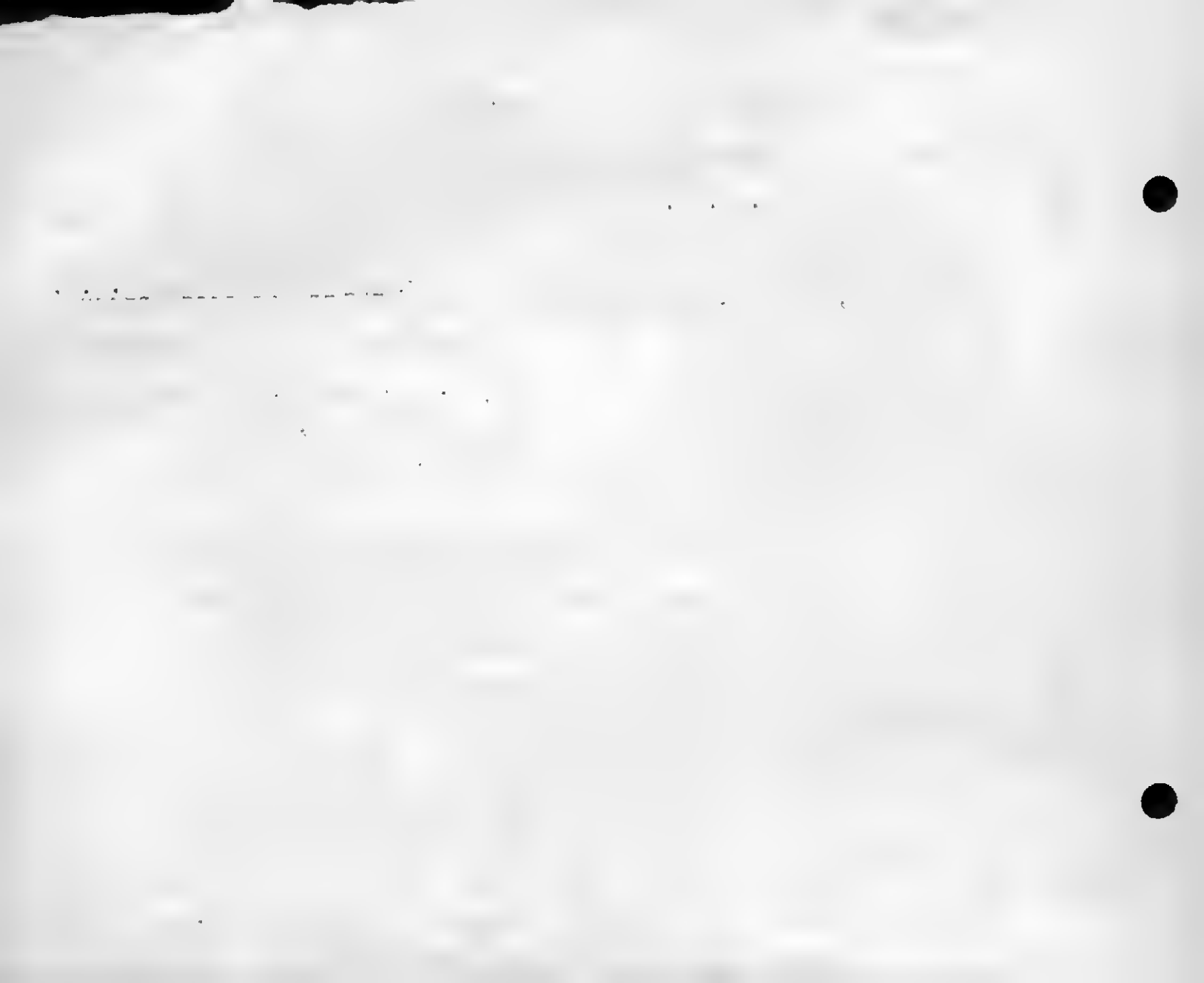
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARANCE WITH MEDICAL EXAMINER.

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or print) Valerie		First	Middle	Last	2a DATE OF DEATH Month May Day 14 Year 1969	2b. HOUR 64 M
3 SEX Female	4 RACE White	5. DATE OF BIRTH July 3, 1902			6 AGE (In years last birthday) 66 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Washington, DC	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Elizabeth's Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution) STATE Washington, DC	13b COUNTY xxxxxxx	13c CITY OR TOWN 2222	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 823 Emerson St. N.W.		
14 FATHER'S NAME JACOB	First Middle Last	15 MOTHER'S MAIDEN NAME Emeline Russell	First Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b SOCIAL SECURITY NO xxxxxx	17 INFORMANT John V. Bollock, Trust Officer Address Nat'l Bank of Washington, Washington, DC				
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF CORONARY OCCLUSION. Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR. 15 YEARS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from JUNE, 1955 , to MAY 14, 1969 , that (I) (we) last saw the deceased alive on MARCH 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE Robert L. Krichmar		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED May 14 1969			
22d PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR		22e ADDRESS 7733 ALASKA AVENUE NW WASHINGTON D.C. 20012				
23a BURIAL, CREMATION, REMOVAL (Specify) Removal	23b DATE 5/16/69	23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d LOCATION (City or Town) (County) (State) Bloomville, Ohio			
24 FUNERAL DIRECTOR The S.H. Davis Co.		ADDRESS 2901 14th St. N.W. Wash D.C.	25a. REC'D BY REGISTRAR MAY 15 1969	25b REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4310

07009

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07005

1 DECEASED-NAME (Type or print) <i>Lydia J. Beehler</i>			2a DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1969</i>			2b HOUR <i>3:30 P.M.</i>	
3 SEX <i>Female</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>9/14/97</i>		6 AGE (in years last birthday) <i>71</i> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____
7a BIRTHPLACE (State or foreign country) <i>Maine</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Secretary</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>		13b COUNTY <i>—</i>		13c CITY OR TOWN <i>Washington</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>3200-11th St. N.W.</i>		14 FATHER'S NAME First <i>Thomas</i> Middle <i>J.</i> Last <i>Simpson</i>		15 MOTHER'S MAIDEN NAME First <i>OLIVE</i> Middle <i>—</i> Last <i>THURSTON</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b SOCIAL SECURITY NO. <i>578-24-1790</i>		17 INFORMANT <i>Vernon Beehler</i>		Address <i>State</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Cerebral Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>21 hours</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertension & Diabetes Mellitus</i>							
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>—</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDINGS, ETC) <i>—</i>		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1965</i> , to <i>May 13, 1969</i> , that (I) (we) saw the deceased alive on <i>May 13, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>P. P. Andrews M.D.</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>5-13-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>P. P. ANDREWS M.D.</i>				22e. ADDRESS <i>Washington D.C. 20016</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5/16/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>ROCKVILLE, MD.</i>	
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SONS</i>				25a. RECD BY REGISTRAR <i>5130 WISCONSIN AVE. N.W. WASHINGTON, D.C.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07010		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07006	
1 DECEASED-NAME (Type or print)		First WARD		Middle C		Last BELL	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 7-27-80		2a. DATE OF DEATH Month 5 Day 21 Year 69	
7a BIRTHPLACE (State or foreign country) OHIO		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6 AGE (In years last birthday) 88 YRS.	
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR LANE N.C. CENTRE		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) M.D.		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution, residence before admission) Calif. Mariposa		13b CITY OR TOWN 1367 COUNTY		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER 5326 N. Prognosis	
14 FATHER'S NAME First DAVID Middle R Last BELL		15 MOTHER'S MAIDEN NAME First ISABELLE Middle CLUTTER Last XXXX		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a) or unknown (b) <input checked="" type="checkbox"/>		16b SOCIAL SECURITY NO 278-32-9586 A 9316	
17 INFORMANT MRS ALISON CARR		Address PINEY BRANCH Rd. SIL. SPG MD.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis - DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate approx 40 yrs 50 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic & Acute Cystitis - post op (many yrs) Carcinoma Penis -							
19a DATE OF OPERATION NOT Recently - 1964 Approx		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ca penis		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7, 1968, to 5/21, 1969, that (I) (we) lost saw the deceased alive on 5/19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Israel Spector MD		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 5/21/69			
22d. PHYSICIAN'S NAME (Type) Israel Spector, MD		22e. ADDRESS 911 Silver Spring Ave., S.S. Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE May 23, 1969		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d LOCATION (City or Town) (County) (State) Bladensburg Rd. Md.	
24 FUNERAL DIRECTOR Warner E. Humphrey, Inc.		ADDRESS 8434 Ga., Ave., S.S.		25a REC'D BY REGISTRAR MAY 26 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07011										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07007																													
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR																													
First Middle Last										Month Day Year										11:50 A																													
3 SEX Male										4 RACE Cau.										5. DATE OF BIRTH Jan. 7, 1896										6 AGE (In years lost birthday) 73 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) New York State										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md.																			
10. CITY OR TOWN OF DEATH Bethesda, Md.										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Lane Nursing Home										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Government Emp.										12b KIND OF BUSINESS OR INDUSTRY Retired																			
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE D.C.										13b COUNTY 13c CITY OR TOWN Washington										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 1336 Missouri Ave., N.W.																			
14 FATHER'S NAME First Middle Last Allen O. Bentley										15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Markham																																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes 1918-1919										16b SOCIAL SECURITY NO 579 60 2230										17 INFORMANT Freda S. Bentley - wife - same item # 13										Address																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours chronic																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) cerebrovascular insufficiency																																																	
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC										21f. LOCATION Street or R.F.D. No. City or Town County State 3/26 69 1 Way 69																													
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on April 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE David Morowitz, M.D.										DEGREE M.D.										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED 1 May '69																			
22d. PHYSICIAN'S NAME (Type) Dr. David Morowitz										22e ADDRESS 9237 Three Oaks Drive, Silver Sprg. Md.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 5/2/69										23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery										23d. LOCATION (City or Town) (County) (State) Prince George Co. Md.																			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home										ADDRESS 1331 Rock Pike Rockville, Maryland										25a REC'D BY REGISTRAR MAY 5 1969										25b REGISTRAR'S SIGNATURE Charles Judge																			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07012 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

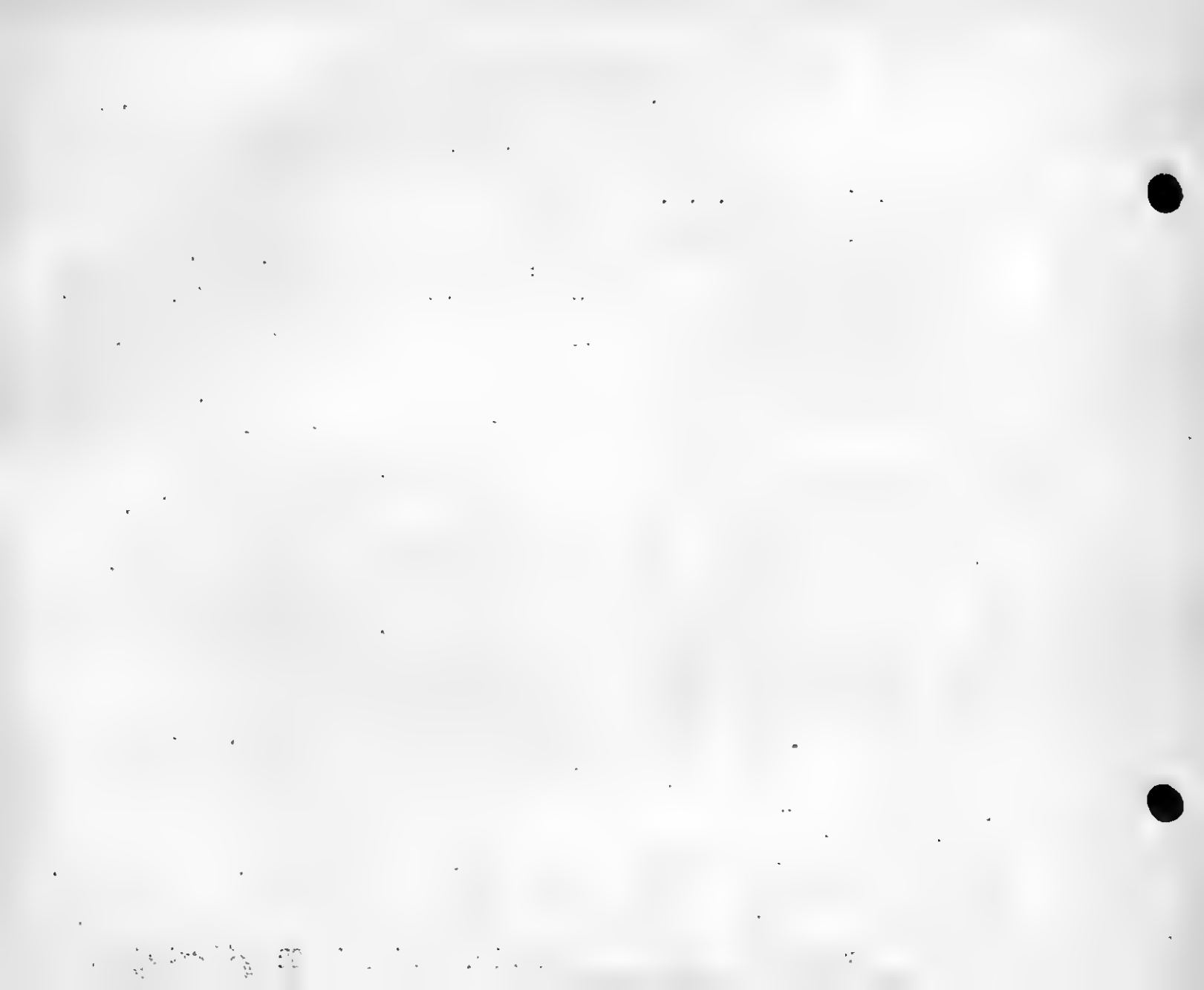
07008

1. DECEASED-NAME (Type or Print) First Sarah Middle Rebecca Last Berg			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month May Day 1 Year 1969			2b. HOUR 5:42 AM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 30, 1880	6. AGE (in years last birthday) 89 YRS	7. IF UNDER 1 YEAR MONTHS 0 DAYS 0	8. IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month May Day 1 Year 1969		
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZENSHIP WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San. + Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -
13a. USUAL RESIDENCE (Where deceased lived, if at institution Residence before admission) STATE Maryland COUNTY Prince George's			13b. CITY OR TOWN Hyattsville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 8211 14th Street		
14. FATHER'S NAME First UNKNOWN Middle - Last -			15. MOTHER'S MAIDEN NAME First Celia Middle - Last UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. NONE			17. INFORMANT Pr's Chart ADDRESS -		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) -								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Read			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED May 1, 1969		
EXAMINER'S NAME (Type) BELDEN R. READ M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City, town, or county) Hyattsville		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/2/69		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cem. Inc.		23d. LOCATION (City or Town) (County) (State) HYATTSVILLE MD		
24. FUNERAL DIRECTOR Goodley Funeral Home				ADDRESS 4217-9th Ave		25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
07013					CERTIFICATE OF DEATH					07009				
1. DECEASED-NAME (Type or print) First Middle Last ALBERT J. BERLIN					2a. DATE OF DEATH Month Day Year 5 16 69					2b. HOUR M M				
3 SEX M		4 RACE White			5 DATE OF BIRTH 9/16/1894			6 AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CIT ZEN OF WHAT COUNTRY? U.S.A.			8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md						
10. CITY OR TOWN OF DEATH Chevy Chase			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda Silver Spring			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Merchant, Ret.			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland					13b. COUNTY Silver Spring			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8505 Springdale Rd.				
14 FATHER'S NAME First Middle Last Samuel Berlin					15. MOTHER'S MAIDEN NAME First Middle Last Anna Hamberger									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO 159-03-7400			17 INFORMANT Address						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4124 Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD (arteriosclerotic cardiovascular disease)</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 1 yr.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic lymphatic leukemia</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>17 Jan, 1966</i> to <i>16 Mar, 1969</i> , that (I) (we) last saw the deceased alive on <i>15 May 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Horace Bernton</i>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Horace Bernton										22e. ADDRESS 4743 Bradley Blvd., Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/18/69		23c. NAME OF CEMETERY OR CREMATORY Roosevelt Cemetery			23d. LOCATION (City or Town) (County) (State) Philadelphia, Pa.						
24 FUNERAL DIRECTOR Bernard Danzansky & Sons										ADDRESS 3501 14th St N.W. Wash., D.C.			25b. REGISTRAR'S SIGNATURE <i>William J. Gage</i>	
										25a. SIGNED BY REGISTRAR MAY 21 1969				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

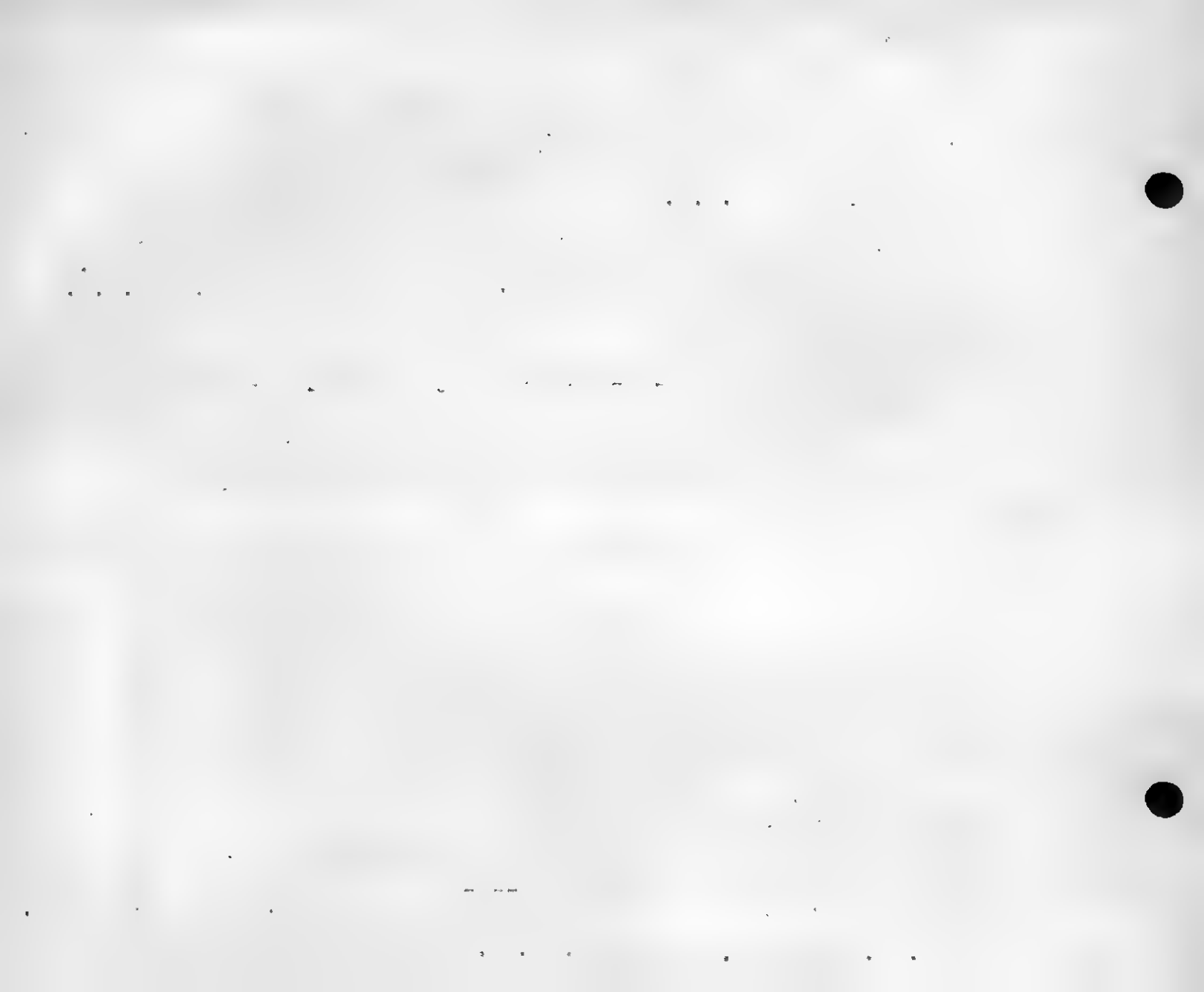
07014

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07010

1 DECEASED-NAME (Type or Print) EMILY A. BETTERIDGE			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 5 Day 12 Year 1969			2b HOUR M
3 SEX Fe	4 RACE CAUC	5 DATE OF BIRTH 3/17/1894	6 AGE (in years) 75	7 UNDER YEAR 12	8 UNDER 24 HRS 12	2c DATE PRONOUNCED DEAD 5 12 Year 1969
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 12336 Peach Orchard Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b KIND OF BUSINESS OR INDUSTRY Laundry
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b COUNTY Washington DC		13c CITY OR TOWN Washington DC	
14 FATHER'S NAME First Henry Middle Fermier Last 			15 MOTHER'S MAIDEN NAME First Agnes Middle Schipe Last 			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO 577-03-8205		17 INFORMANT Terrence Betteridge - same as above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency						
DUE TO, OR AS A CONSEQUENCE OF, (b) Arteriosclerotic Heart Disease						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
DUE TO, OR AS A CONSEQUENCE OF, (c) 						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion						
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED MAY 12, 1969		
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (City or Town) (County) (State)		
23a BURIAL CREMATION, REMOVAL (Specify) burial		23b DATE 5/14/69		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION (City or Town) (County) (State) Montgomery County, Md.
24 FUNERAL DIRECTOR The S. H. Hines Co. Washington, D. C.				25a REC'D BY REGISTRAR MAY 14 1969		25b REGISTRAR'S SIGNATURE J. C. Jones



M. L. White, D.D. covering for Benet, D.D. Reynolds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

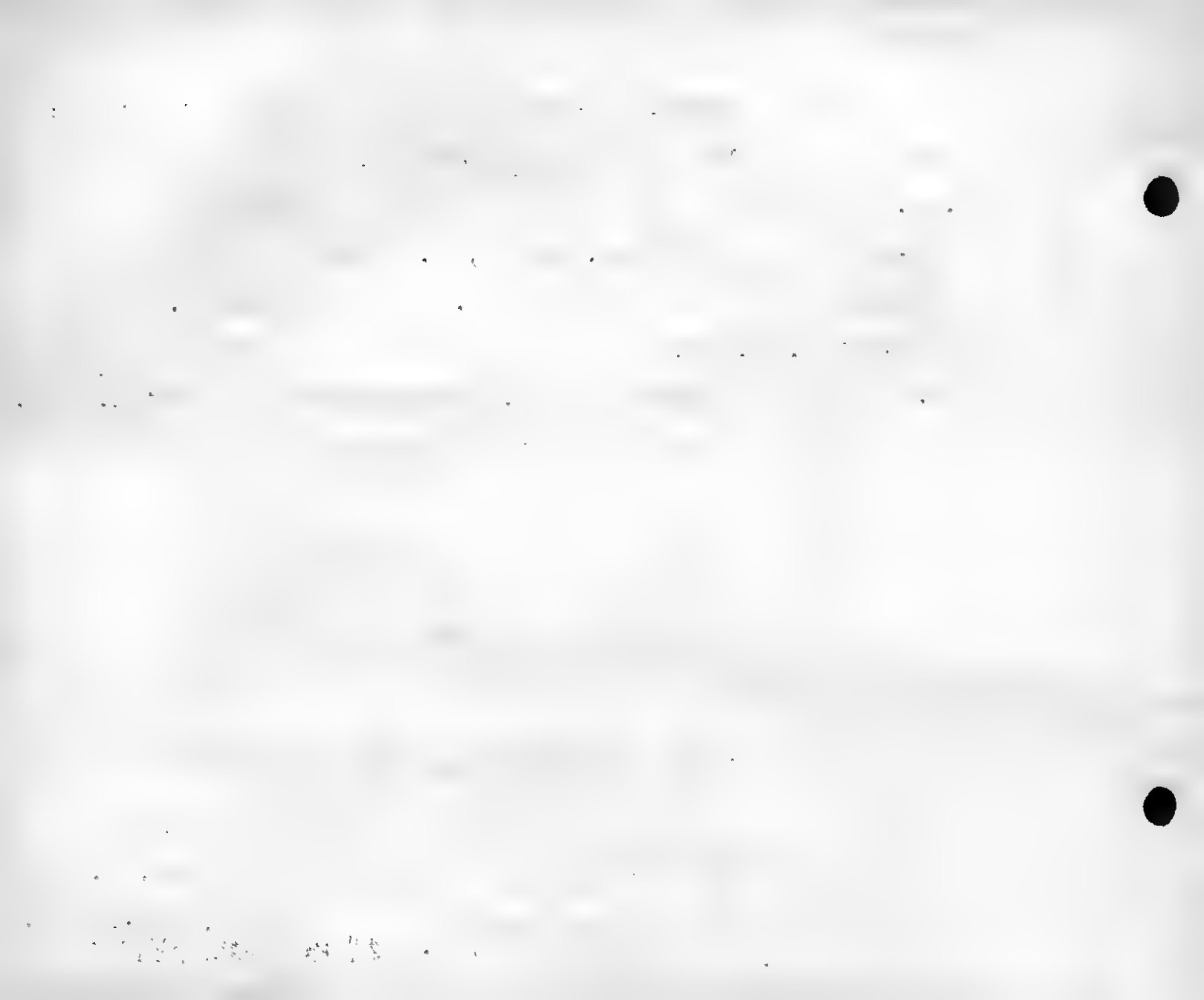
07015										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07011									
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR									
First Edith Middle PEARL Last Bielaski										Month May Day 25 Year 1969										1P M									
3 SEX Female										4 RACE Caucasian										5 DATE OF BIRTH 12-1-79									
6 AGE (In years last birthday) 89 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
7a BIRTHPLACE (State or foreign country) V.A.										7b CITIZEN OF WHAT COUNTRY? UNITED STATES										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
9. COUNTY OF DEATH Montgomery										10 CITY OR TOWN OF DEATH Silver Spring										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross									
12a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.										13b COUNTY Montgomery										12b USUAL OCCUPATION (Kind of work done during most of working life, even if retired) AT HOME									
13a STREET AND NUMBER 2407 Glenallen Ave #3										13b INS DE CTY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13c CITY OR TOWN Silver Spring									
14 FATHER'S NAME First James Middle Hugh Last Harrington										15. MOTHER'S MAIDEN NAME First Mary Middle Ann Last KERNY Harrington										Address WASH, D.C., 2801 NEW MEXICO AVE.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO										16b SOCIAL SECURITY NO. 215-54-8345										17 INFORMANT JAMES BIELASKI, SON, 2801 NEW MEXICO AVE.									
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)										PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) <u>Myocardial Infarction</u>										(c) <u>Generalized Arteriosclerosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										<u>Cholecystectomy. Gallstones after cholecystectomy</u>																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>12 May, 1969</u> to <u>25 May, 1969</u> , that (I) (we) last saw the deceased alive on <u>24 May, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d,d) (d,d) (d,d) (d,d) view the body after death.										22b SIGNATURE Merton L. White MD										22c DATE SIGNED 25 May 69									
22d. PHYSICIAN'S NAME (Type) Merton L. White										22e ADDRESS 9911 Georgia Ave. N.W. Silver Spring, Maryland																			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial										23b DATE 5-28-1969										23c NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery									
23d LOCATION (City or town) (County) (State) Washington, D.C.										24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016										25a REC'D BY REGISTRAR DATE MAY 28 1969									
25b REGISTRAR'S SIGNATURE Charles Yager																													

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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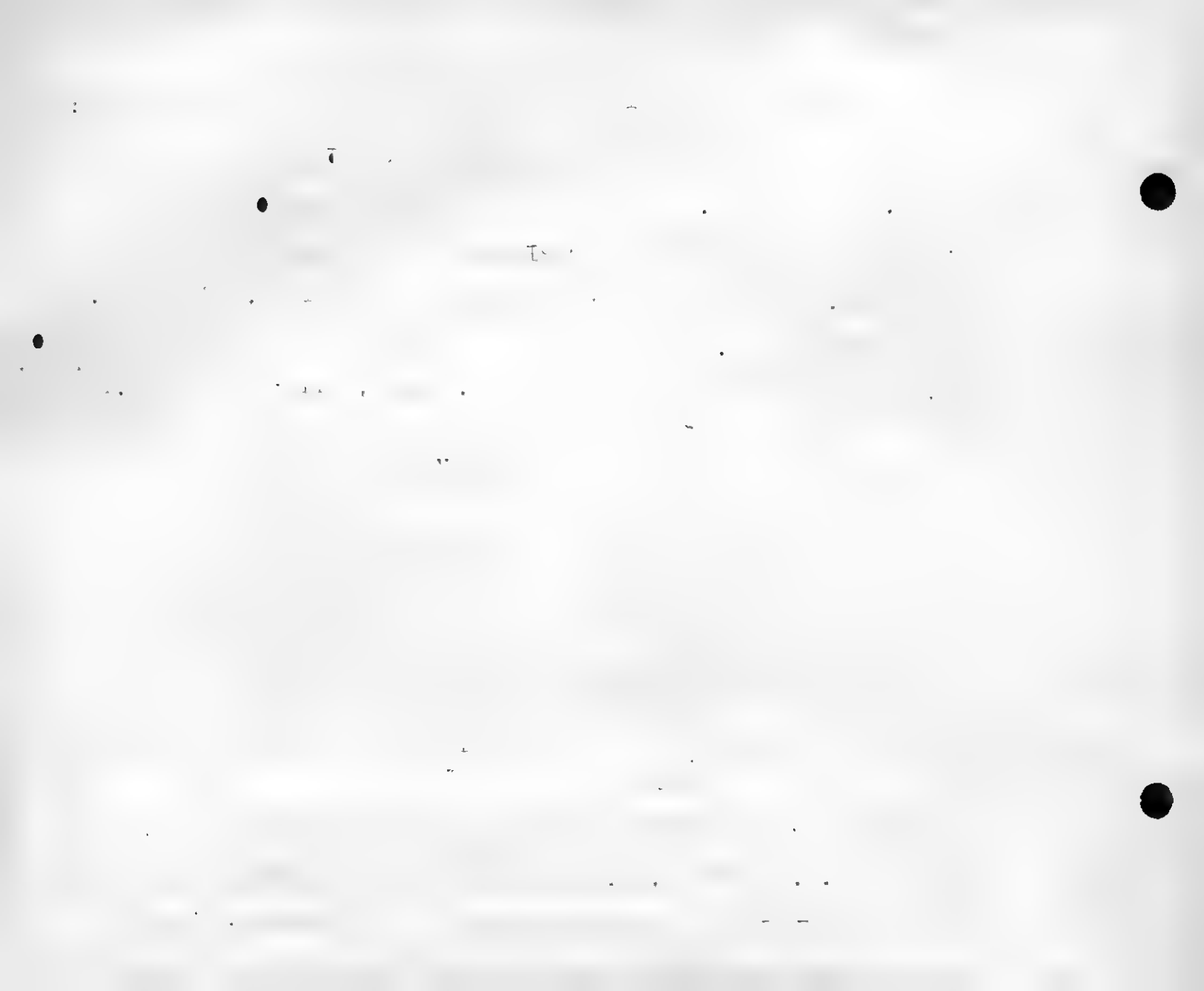
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JAMES BERNARD BLACKWOOD						MAY 17 1969			8:55AM
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE	CAUC		27 JUNE 1908			60 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. VA.		USA				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			NAVAL HOSP. BETHESDA, MD.			USMC			
13a USUAL RESIDENCE (Where deceased lived, if institution)			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
MARYLAND					SILVER SPR.		YES <input type="checkbox"/> NO <input type="checkbox"/>		915 GABEL ST.
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
FRANKLIN J. BLACKWOOD			MARGARET DEBOLT						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)			16b SOCIAL SECURITY NO		17. INFORMANT Address				
YES			WTTT		234 44 2190 MRS. MARGARET BLACKWOOD, 915 GABEL ST. MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									11 MONTHS
IMMEDIATE CAUSE (a) CARCINOMA OF LUNG WITH METASTASES									
DUE TO, OR AS A CONSEQUENCE OF									
1621									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1b.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year							
		P.M. 19							
21a INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No					
22a. I certify that (he) (this hospital) attended the deceased from 9 MAY, 1969, to 17 MAY, 1969, that (he) (we) last saw the deceased alive on 17 MAY, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED
James Trone									17 May 1969
22d PHYSICIAN'S NAME (Type)					22e. ADDRESS				
CDR JAMES TRONE, MC, USN					NAVAL HOSPITAL, BETHESDA, MD.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		May 20, 1969		ARLINGTON CEMETARY		ARLINGTON, ARLINGTON, VA.			
24. FUNERAL DIRECTOR					SILVER SPRINGS, MD.		REC'D BY REGISTRAR		25a REGISTRAR'S SIGNATURE
COLLINS FUNERAL HOME 500 UNIVERSITY BLVD WEST					MAY 22 1969				William Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
HELEN JULIA BOYLE						MAY 10 1969			3:10 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		CAUCASIAN		AUGUST 8, 1919		49 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PA		USA				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			US NAVAL HOSPITAL			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
VA			N		ALEXANDRIA	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 511 E. LURAY AVE.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
FRANK J. BREINER						MARY UNKNOWN REINOLD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
NO						LEO J. BOYLE, 511 E LURAY AVE., ALEX- ANDRIA, VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE BREAST WITH METASTASES									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 28 APRIL, 1969, to 10 MAY, 1969, that (X) (we) last saw the deceased alive on 10 MAY, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (did not) view the body after death.									
22b. SIGNATURE H.E. Ashworth M.D.						22c. DATE SIGNED 5-10-69		22d. PHYSICIAN'S NAME (Type)	
H.E. ASHWORTH, MD.						NAVAL HOSPITAL BETHESDA MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			5-14-69		Arlington National		Fort Myer, Virginia		
24. FUNERAL DIRECTOR Alexandria, Va. Person						25a. REC'D BY REGISTRAR DATE MAY 15 1969		25b. REGISTRAR'S SIGNATURE	



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07018

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07014

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Verna	Middle H.	Last BOYLE	2a. DATE OF DEATH Month Day Year May 26 69		2b. HOUR 4:30 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH 30 January 1894		6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Minnesota	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Julius		Middle	Last Herman	15. MOTHER'S MAIDEN NAME First Unknown		Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 579-44-7602B		17. INFORMANT Bethesda, Md. Mr. John C. Boyle, 4400 East West Highway		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease, severe, associated with bronchial asthma							
41 DUE TO, OR AS A CONSEQUENCE OF (b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that this hospital attended the deceased from May 23, 1969, to May 26, 1969, that (I) (we) last saw the deceased alive on May 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE D. S. Horton, M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED May 27, 1969	
22d. PHYSICIAN'S NAME (Type) D. S. HORTON, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/28/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.	
24. FUNERAL DIRECTOR Jos. Gawler Sons 5130 Wisconsin Ave., N.W. Washington, D.C.				25a. REC'D BY REGISTRAR DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

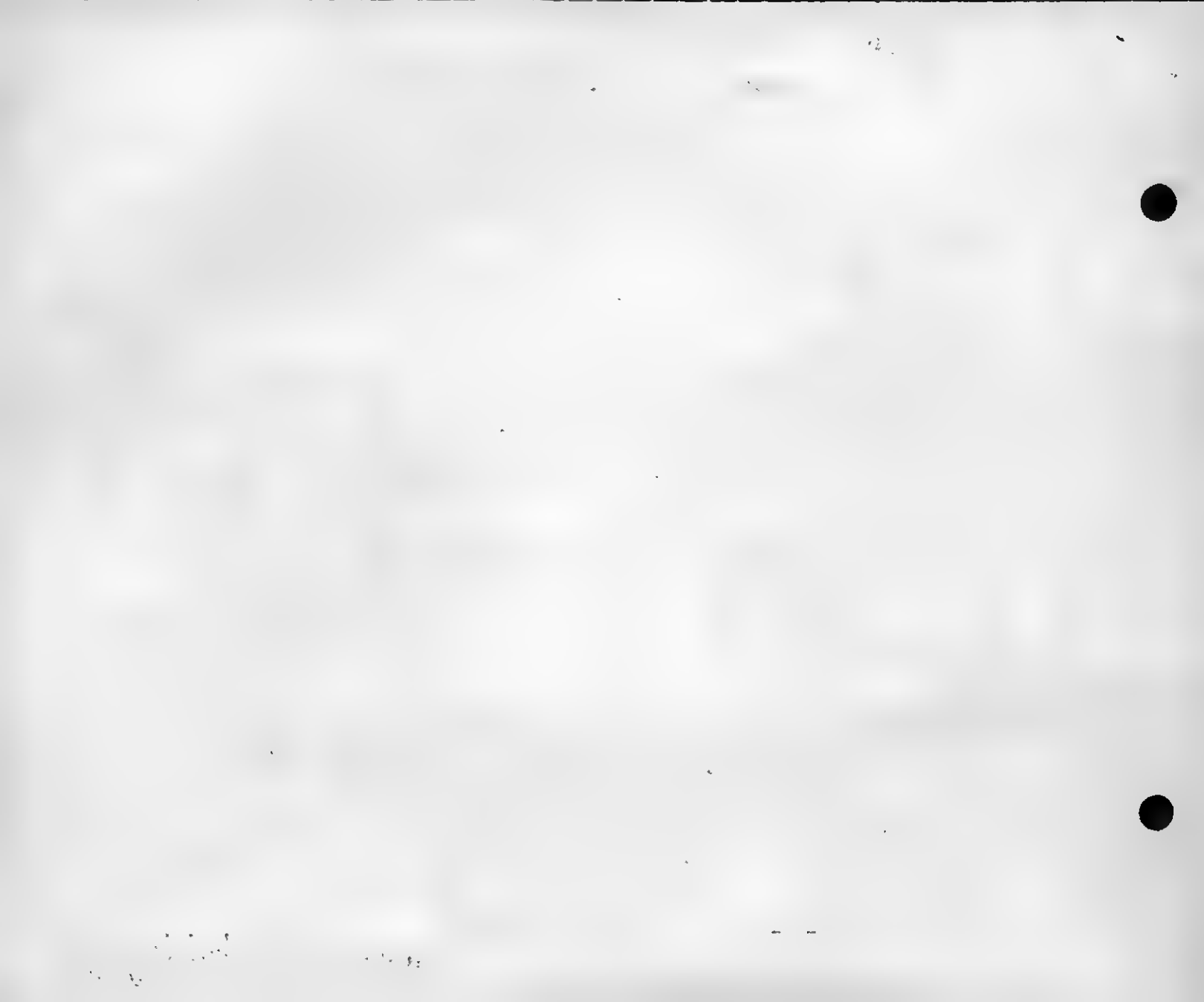
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07019						07015					
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Agatha</i>			First <i>Agatha</i> Middle <i>C.</i> Last <i>Bradbury</i>			2a. DATE OF DEATH Month <i>5</i> Day <i>20</i> Year <i>69</i>			2b. HOUR <i>5:20 PM</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>10-30-88</i>			6. AGE (In years last birthday) <i>80</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Mass</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Chevy Chase</i>			13d. INS. OF CITY, UN. INS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>John</i> Middle <i>Carney</i> Last <i>Katherine</i>			15. MOTHER'S MAIDEN NAME First <i>Katherine</i> Middle <i>Neighan</i> Last <i>Neighan</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>-</i>		
17. INFORMANT <i>MRS. LONG D. CHAMBLISS, DAUGHTER, BETH, MD.</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hepatic Failure, severe</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cirrhosis of the Liver Severe</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>6 months</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1949</i> to <i>MAY 20, 1969</i> , that (I) (we) last saw the deceased alive on <i>MAY 20, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stewart Clapp M.D.</i>			22c. DATE SIGNED <i>5-20-1969</i>			22d. PHYSICIAN'S NAME (Type) <i>Stewart Clapp M.D.</i>			22e. ADDRESS <i>5415 W. Cedar Lane Bethesda Md</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>5-23-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>		
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, INC.</i>			25a. REC'D BY REGISTRAR <i>MAY 23 1969</i>			25b. PHOTOGRAPH SIGNATURE <i>John D. Judge</i>					



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07020		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH		07016	
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
LLOYD		F.		BRAIN SR.	Month Day Year 5 / 4 / 69		10:57AM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
MALE		CAUCASIAN		9-18-97		71 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Iowa		U. S. A				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA, MD.		GROSVENOR LANE NURSING HOME		owner appliance store		Electric			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY L.M. TSP		13e. STREET AND NUMBER			
MD.		P.G.		RIVERDALE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5406 KENILWORTH AVE.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
JAMES			HENRY	BRAIN	MARY			ELIZABETH	SIMPSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
yes		none		578-20-02-73		MARGARET A BRAIN		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
100X				Respiratory insufficiency		Hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)		1 year			
				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No City or Town County State				
					574 69				
22a. I certify that (I) (this hospital) attended the deceased from Oct. 8, 1968, to May 4, 1969, that (I) (we) last saw the deceased alive on May 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)			22e. ADDRESS		22d. DATE SIGNED		
David Morowitz, md		David Morowitz, md			Bethesda, md		5/14/69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/7/69		Ft. Lincoln		Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons		Hyattsville, Md.			MAY 7 1969		Francis Gasch		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07017

07021

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED			<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR
JOHN				NMN	BRANDON	5			19	19	69	3:20 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD			2d HOUR	
MALE	NEGRO	6-17-39	29					Month 5 Day 19 Year 69			3:20 PM	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
NORTH CAROLINA			USA					MONTGOMERY				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
OLNEY			MONTGOMERY GENERAL			TRUCK DRIVER			SAND COMPANY			
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, ANY?		13e STREET AND NUMBER			
DISTRICT OF COLUMBIA					WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6100 14TH ST., N. W.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
JOHN					BRANDON	ELIZABETH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			
NO			577540937			MEDICAL RECORDS DEPT.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple internal injuries with												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
(b) exsanguination, incurred in truck accident.												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				HOJCAJL 2:45 PM 5-19-69				deceased driving alone was thrown beneath truck when it struck tree and pole				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No. City or Town County State				
				Street Rte 108 & Little River				Howard Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				MAY 19, 1969				
BELDEN R. DEARPH.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
				ADDRESS (City or Town, County, State)								
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				
Burial				May 24/69				Harmony Memorial Park				
								Landover R. Geo. Co. Md.				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				
Martell Adams				Aguasco, Md.				DATE JUN 2 1969				
								25b. REGISTRAR'S SIGNATURE				
								[Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07022

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Emma Evelyn Brierly			2a DATE OF DEATH 5 Month 9 Day 69		2b HOUR 10⁰⁰ PM
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH 12/25/78		6 AGE (In years last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Mississippi	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 10610 Mantz Road	
14 FATHER'S NAME First Middle Last Thomas H. Brierly	15. MOTHER'S M A DEN NAME First Middle Last Fannie Mae Hughes		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. 486-01-2524		17 INFORMANT Mrs. Gerald Ashour		Address 10610 Mantz Road SS.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 007.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bacterial infection DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (At home farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to May 9 , 19 69 , that (I) (we) last saw the deceased alive on May 9 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Edward Richards M.D.			22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)
22e ADDRESS			22f. DATE SIGNED		
23a (BURIAL) CREMATION, REMOVAL (Specify)	23b DATE 5/14/69	23c NAME OF CEMETERY OR CREMATORY Mt. Washington Cem.		23d LOCATION (City or Town) (County) (State) Kansas City Mo.	
24. FUNERAL DIRECTOR W. W. Chambers		ADDRESS 1400 Chapman St.		25a REC'D BY REGISTRAR MAY 15 1969	
				25b. REGISTRAR'S SIGNATURE [Signature]	

445-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07023

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07019

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Phillip Henry Bright			2a DATE OF DEATH 5 Month 17 Day 69 Year			2b HOUR 1:55AM							
3 SEX Male		4 RACE Colored		5 DATE OF BIRTH 8-2-94		6 AGE (in years last birthday) 74 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Howard			13c CITY OR TOWN Dayton		13d INSIDE CITY (LIMITS?) YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Green Bridge Rd.			
14. FATHER'S NAME First Middle Last Phillip Bright			15. MOTHER'S MAIDEN NAME First Middle Last Mary E. Giles										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: 405X IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILAT. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) APLASTIC ANEMIA													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 4/19, 1966 , to 5/17, 1969 , that (I) (we) lost the deceased alive on 5/16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b SIGNATURE Charles S. Whitaker M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/17/69					
22d. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.						22e. ADDRESS CLARKSVILLE, MD.							
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 5/20/69		23c NAME OF CEMETERY OR CREMATORY Browns Chapel Cemetery				23d LOCATION (City or Town) (County) (State) Dayton, Howard, Maryland					
24. FUNERAL DIRECTOR Robert L. Lucowden				ADDRESS Rockville, Maryland				25a REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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Handwritten scribbles or marks at the bottom left corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exercised within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
07024		CERTIFICATE OF DEATH						07020					
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR 1 30 AM		
Dorothy			C.		Brooke				5 28 69				
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female			Cae.			1-4-03			66 YRS.				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH		Md.		
Maryland			U.S.A.						Montgomery				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY				
Silver Spring			Home 1000 Daleview Dr.			spoke clock			Road Court				
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
md.			P.G.			Mitchellville			YES		11401 Belvedere Rd.		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S M.A.D.E.N. NAME		First Middle Last		
Herbert			G.		Hopkins				Fannie		L. Moore		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address				
(If yes give war or dates of service)			578-62-5601			Lucia H Starkey			11401 Belvedere Rd Mitchellville				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:										6 mo			
IMMEDIATE CAUSE (a) <u>Astrocytoma</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 1b)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>60</u> , to <u>May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 27</u> , 19 <u>64</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS				
Peyton R. Evans Jr MD			May 28, 1969			Peyton R. Evans Jr.			4900 Mass. Ave. Wash DC 20006				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			June 2, 1969			St. Paul Episcopal Cemetery			Alexandria, Virginia				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Warner E. Pumphrey, Inc., Silver Spring, Md.			JUN 3 1969			John M. Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07025 8/15/69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
Item 5 Film 3413 5/29/69 kk																	
CERTIFICATE OF DEATH																	
07021																	
1 DECEASED NAME (Type or print)			First MOSES			Middle C.			Last BROOKS			2a. DATE OF DEATH Month Day Year 5 - 18 - 69			2b. HOUR 11:30 AM		
3 SEX MALE			4 RACE NEGRO			5. DATE OF BIRTH 9 - 4 - 1894			6 AGE (In years last b (day) YRS 68 YRS			7 UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HOURS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md								
10 CITY OR TOWN OF DEATH BETHESDA			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR LANE NURSING HOME			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
13a US.A. RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE D.C.			13b COUNTY ✓			13c CITY OR TOWN WASHINGTON			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 636-S Street NW 2ND HMD/CLURE/ST					
14 FATHER'S NAME William H. Brooks			First Middle Last			15 MOTHER'S MAIDEN NAME Annie R. Brooks			First Middle Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOCIA. SECURITY NO 511-09-0400			17 INFORMANT RUD. W. GAINES			Address 3443 Holmwood Pl. NW								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction																	
DUE TO, OR AS A CONSEQUENCE OF (b) coronary atherosclerosis																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) chronic bronchitis and emphysema																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (the hospital) attended the deceased from 5:15 to 5:18, 1969, that (I) (we) last saw the deceased alive on 5/15/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b SIGNATURE David A. Brown, M.D.			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED 5/18/69								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 5/22/69			23c NAME OF CEMETERY OR CREMATORY Harmony Memorial			23d LOCAT-ON (City or Town) (County) (State) Landover Md.								
24 FUNERAL DIRECTOR R.N. HORTON			25a REC'D BY REGISTRAR MAY 22 1969			25b REGISTRAR'S SIGNATURE Richard Judge											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

07026

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <i>Edward Hutchins Brown</i>			2a. DATE OF DEATH 5 Month 10 Day 69 Year			2b. HOUR 8:50 M					
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH 6-9-84		6 AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>England</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md					
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired - Insurance-Salesman</i>		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md.</i>		13b COUNTY <i>mont.</i>		13c CITY OR TOWN <i>Bethesda</i>		13d WAS DE CITY IN 1957? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>10600 Kenilworth Ave.</i>			
14 FATHER'S NAME First Middle Last <i>John T. Brown</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>(Unknown)</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>505-16-7845</i>		17 INFORMANT <i>Son-in-law</i>		Address <i>Same as Item 13.</i>					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF <i>Associated with</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Emphysema & chronic bronchitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive heart failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>4</i> Years <i>4</i> Years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>occlusion left subclavian artery, nephrosclerosis, myocarditis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/7/69</i> , 19 <i>69</i> , to <i>5/10/69</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/10/69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Allen J. O'Neill</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/10/1969</i>					
22d. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		22e. ADDRESS <i>Bethesda MD</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-14-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Merchantville, N. J.</i>					
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>MAY 15 1969</i>		25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07023

1. DECEASED-NAME (Type or print) JAMES		First JAMES		Middle ALGER		Last BROWN		2a. DATE OF DEATH 5 Month 25 Day 69 Year		2b. HOUR 1:15 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 7-11-17		6 AGE (In years last birthday) 51 YRS		IF UNDER 1 YEAR MONTHS 51 DAYS 11 HOURS 15 MIN		IF UNDER 24 HRS. HOURS 1 MIN 15 SEC	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Locomotive Engineer		12b. KIND OF BUSINESS OR INDUSTRY B & O Railroad					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. dence before admission) STATE Maryland COUNTY Montgomery		13b. CITY OR TOWN Germantown		13c. INSIDE CITY L.M. 1ST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER Box 119					
14 FATHER'S NAME First James Middle Brown Last Brown		15 MOTHER'S MAIDEN NAME First Bertha Middle Hall Last Hall									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown yes (If yes give year or dates of service.)		16b. SOCIAL SECURITY NO 218-12-0450		17 INFORMANT Doris A. Brown - wife of deceased Admission Recd., Montgomery Gen. Hospital, Olney							
18. CAUSE OF DEATH (Enter only one cause per Part I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Tuberculosis & Fatty abscess 0150 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from Feb 2, 1969 , to May 25, 1969 , that (I) (we) last saw the deceased alive on May 24, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frederick Mooman M.D.		22c. DATE SIGNED 5-26-69		22d. PHYSICIAN'S NAME (Type) Frederick Mooman, M.D.		22e. ADDRESS Medical Center, Sandy Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE May 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Parble Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Md.					
24. FUNERAL DIRECTOR Robert F. Humphrey, Inc. 8434 Ca. Ave. Sil. Spg.		25a. RECD BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages one and two should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

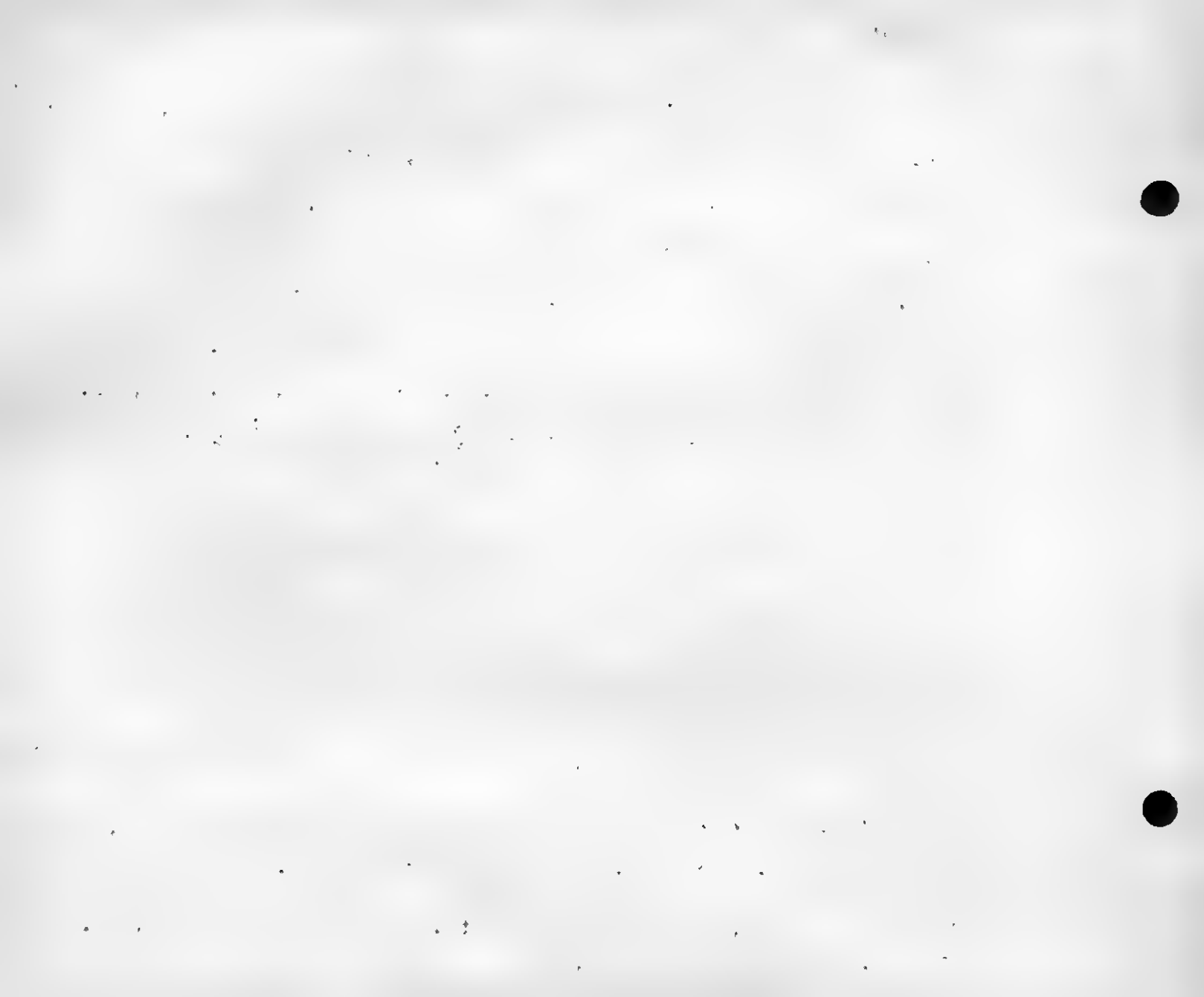
07028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07024

1 DECEASED NAME (Type or print) Rosie J. Brown			2a DATE OF DEATH Month May Day 16 Year 1969			2b HOUR 4:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 31, 1899		6 AGE (In years last birthday) 69 YRS.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Mt. Airy		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RFD # 3		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Mt. Airy		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				13e STREET AND NUMBER RFD # 3			
14 FATHER'S NAME First Middle Last Chaplin Beall			15. MOTHER'S MAIDEN NAME First Middle Last Priscilla J. Beall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT Address Mr. R. Dewey Brown, Mt. Airy, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the colon with generalized metastases 153.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8/16 , 19 47 , to 5/16 , 19 69 , that (I) (we) last saw the deceased alive on 5/16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE James P. Kerr				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED May 16, 1969	
22d. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.				22e ADDRESS Damascus, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 18, 1969		23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		23d. LOCATION (City or Town) (County) (State) Clagettville, Md.	
24 FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				25a REC'D BY REGISTRAR MAY 20 1969		25b REGISTRAR'S SIGNATURE Maxine H. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07029					07025				
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Danielle			NM		BRYAN	May 28 1969			2:00 PM
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 YRS.
Female		Cauc		17 May 1969					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		USA					Montgomery Md.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Naval Hospital, Beth Md			None			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. CITY OR TOWN		13c. INSIDE CITY L.H. 157		13e. STREET AND NUMBER	
Virginia				Fairfax		YES <input type="checkbox"/> NO <input type="checkbox"/>		2202 Troquois Lane	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Herbert Francis Bryan						Susan Bowry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			NONE			Herbert F. Bryan 2202 Troquois Lane Falls Church, Va			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Neonatal Sepsis									
038.9 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town	County State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (he) (this hospital) attended the deceased from 23 May, 1969, to 28 May, 1969, that (he) (we) last saw the deceased alive on 28 May, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Franklin X. Loeb					28 May 1969				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Franklin X. Loeb					Naval Hospital, Bethesda, Maryland				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		6-2-1969		Arlington Hall Cem		77 Myers			Va.
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W.W. Chambers Funeral Home, 3072-17 St Md.		JUN 2 1969		Charles Judge					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month 5 Day 25 Year 69		2b. HOUR 11:30 A.M.
3. SEX Female		4. RACE white		5. DATE OF BIRTH 5/24/69		6. AGE (in years last birthday) YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 12		IF UNDER 24 HRS HOURS 15 MIN 55
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Co. - Md				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4006 Decatur Ave		
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Chart						
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia & Sepsis</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 11:24, 1969, to 5:25, 1969, that (I) (we) last saw the deceased alive on 5/24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death										
22b. SIGNATURE Arthur G. Kreischer M.D. DEGREE										22c. DATE SIGNED 5/25/69
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/26/69		23c. NAME OF CEMETERY OR CREMATORY Suburban Hospital		23d. LOCATION (City or Town) (County) (State) Bethesda - Montgomery - Md		23e. FILED BY REGISTRAR MAY 29 1969		23f. REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Mrs. Amelia C. Carter, Administrator										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07031

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07027

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Della W. Burdette</u>			2a. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>69</u>			2b. HOUR <u>5:40 A.M.</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>6-30-84</u>		6. AGE (In years last birthday) <u>84</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Operated Funeral Home</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Damascus</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>26401 Ridge Rd.</u>							
14. FATHER'S NAME First Middle Last <u>William T. Lewis</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Laura Williams</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <u>No</u>		16b. SOCIAL SECURITY NO. <u>579-64-7782</u>		17. INFORMANT <u>Austin L. Beall</u>			
				Address <u>813 Miss Ave N.E. Wash. D.C.</u>			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>Renal Insufficiency, Diabetes Mellitus, Urinary Tract Infection</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>5/1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Norman H. Rubenstein M.D.</u>				22c. DATE SIGNED <u>5/1/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein, M.D.</u>				22e. ADDRESS <u>11161 N.H. Ave Silver Spring, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <u>May 3, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>		23d. LOCATION (City or Town) (County) (State) <u>Damascus, Md.</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>6 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14 07032

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07028

1. DECEASED NAME (Type or print) First Middle Last SARAH Frances BURRISS			2a. DATE OF DEATH Month Day Year 5-11-69			2b. HOUR 8:12 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH 3-11-86		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. HOSP.		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY Housekeeper	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY PG		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY L.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7418 14TH AVE, #101		14. FATHER'S NAME First Middle Last David - KNIGHT		15. MOTHER'S MAIDEN NAME First Middle Last unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-36-2869		17. INFORMANT Herman D. Burriss (Son) Mr. Rainier, Md. 3103 Queens Chapel Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 acute pulmonary insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic granulomatous lung disease with Cavitation CHRONIC DUE TO, OR AS A CONSEQUENCE OF (c) undetermined (? Tbc)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 d
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) acute pneumoniae both lower lobes							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/3, 1969, to 5/11, 1969, that (I) (we) last saw the deceased alive on 5/10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Henry W. Stout MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/12/69	
22d. PHYSICIAN'S NAME (Type) HENRY W. STOUT MD		22e. ADDRESS 10011 GEORGIA AVE SILVER SPRING MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cem.		23d. LOCATION (City or Town) (County) (State) Burtonsville Maryland	
23e. FUNERAL DIRECTOR C. Glen Carter Silver Spring, Maryland Warner E. Pumphrey, Inc., 8434 Georgia Avenue				25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE William J. Judge	

FOR STATE HEALTH DEPT.

TO **MEDICAL EXAMINER**: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO **FUNERAL DIRECTOR**: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07033

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07029

1 DECEASED-NAME (Type or Print)		First Glenn	Middle William	Last Code 111	2a DATE KNOWN OF DEATH EST MATED <input checked="" type="checkbox"/> 5-24-69 19		2b HOUR 143
3 SEX Male	4 RACE White	5 DATE OF BIRTH 1-27-63	6 AGE (in years last birthday) 6 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 5 24 19 69	2d HOUR 143
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Toloma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sen C Hosp		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b CITY OR TOWN Prince George		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1911 Red Oak Dr.	
14 FATHER'S NAME Glenn William		15 MOTHER'S MAIDEN NAME Christine		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO	
17 INFORMANT Tous Chart		18 ADDRESS Ross		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DATE OF OPERATION 7:00 A.M. 5-21-69		21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 5-21-69	
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1b or Part 2b) Deceased killed playing with pistol shot self in left eye		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No 1911 Red Oak Dr.	
22a I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b DATE SIGNED MAY 24, 1969		23a BUREL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/26/69	
23c NAME OF CEMETERY OR CREMATORY Fort Lincoln cemetery		23d LOCATION (City or Town) (County) (State) Bladensburg Md.		24. FUNERAL DIRECTOR Paul J. Smith		25a REC'D BY REG STRAR MAY 27 1969	
25b REGISTRAR'S SIGNATURE Charles Judge		25c ADDRESS Warner E. Humphrey, inc. 8434 Ya. ave Sil. Spr.		25d ADDRESS		25e ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07034

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07030

1. DECEASED-NAME (Type or print) First Middle Last Frank (Francis) P. Cahill			2a. DATE OF DEATH Month 5 Day 18 Year 69		2b. HOUR 1A M
3. SEX M	4. RACE Can	5. DATE OF BIRTH 2-20-1892		6. AGE (In years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>	9. COUNTY OF DEATH montgomery Md		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cherry Chase Conv. Center	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) us army Engineer	12b. KIND OF BUSINESS OR INDUSTRY Civ. Engineer		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md	13b. COUNTY montgomery	13c. CITY OR TOWN Silver Spr.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER R361 16th St.	
14. FATHER'S NAME First Middle Last michael		15. MOTHER'S MAIDEN NAME First Middle Last margaret Morrison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO. 215-44-5575A	17. INFORMANT Address m. jansen RN Cherry Chase Conv. Center			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 4119 IMMEDIATE CAUSE (a) Cardiac & Cerebral Ischemia DUE TO, OR AS A CONSEQUENCE OF Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-12 days 3-5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from June 3, 1959 to May 18, 1969 , that (I) (we) last saw the deceased alive on May 18, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W.B. Wardrop MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) W.B. WARDROP MD		22e. ADDRESS 808 PERSHING DRIVE SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 21, 1969	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Mont. Md.	
24. FUNERAL DIRECTOR James J. Callis		ADDRESS 500 Community Blvd W Silver Md		25a. REC'D BY REG STRAR MAY 22 1969	25b. REG STRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

07035

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07031

1 DECEASED NAME (Type or print) First Middle Last LUCE MAY CALLAHAN			2a. DATE OF DEATH Month Day Year May 8 1969		2b. HOUR 10:14 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH May 7, 1882		6 AGE (In years lost birthday) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Salisbury, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Kensington, Md.	NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Kensington Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY CYCN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md	13b. COUNTY BALTIMORE	13c. CITY OR TOWN OWINGS MILLS	13d. INSIDE CITY, LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 114 Pleasant Hill Rd.	
14 FATHER'S NAME First Middle Last CHARLES KOHL			15 MOTHER'S MAIDEN NAME First Middle Last KATHERINE KANSHER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	(Yes give war or dates of service) Stone	16b. SOCIAL SECURITY NO. unknown	17 INFORMANT MRS. FRANCES W. SATTERFIELD 131 DODGEM		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Heart Conditions, if any, which gave rise to immediate cause (c) stoking the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Semility					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1966 , to May 8, 1967 , that (I) (we) last saw the deceased alive on 6 May 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE Joacel Bernhart		DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE May 10, 1969	23c. NAME OF CEMETERY OR CREMATORY Mount St. Joseph		23d. LOCATION (City or Town) (County) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR Frank H. Howell		ADDRESS Pikesville, Md.		25. RECEIVED BY REGISTRAR MAY 12 1969	25b. REGISTRAR'S SIGNATURE James J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

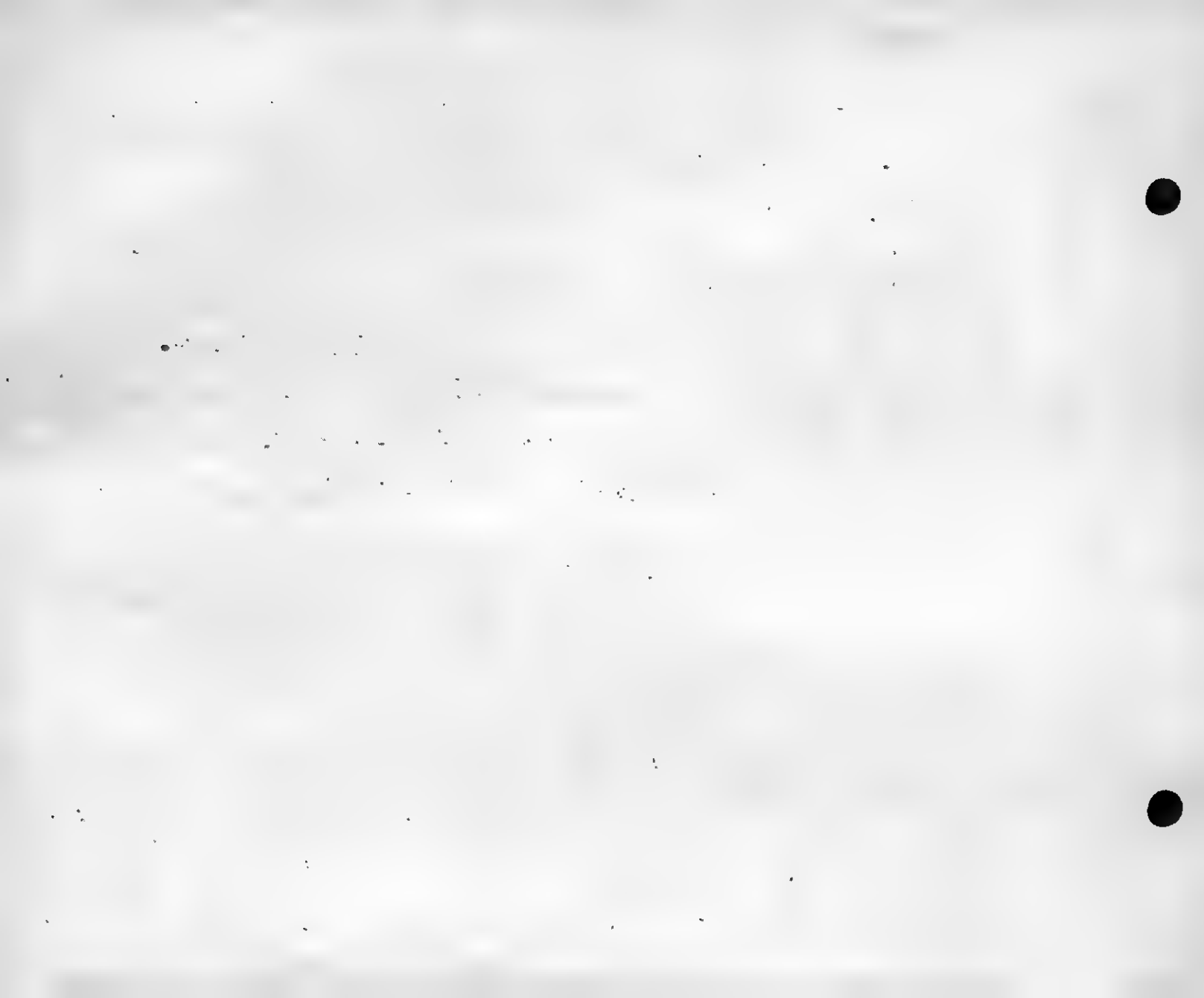
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07036

CERTIFICATE OF DEATH

07032

1 DECEASED-NAME (Type or print) W. KENNETH		First Middle Last CARLIN		2a DATE OF DEATH Month Day Year MAY 28 1969		2b HOUR 1 30 P. M.	
3 SEX Male		4. RACE White		5. DATE OF BIRTH Jan 9 - 1887		6 AGE (In years last birthday) 82 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Boyd's - Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) Farm owner		12b KIND OF BUSINESS OR INDUSTRY Farming	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Montg.		13c CITY OR TOWN Boyd's		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last John Thomas Carlin		15 MOTHER'S MAIDEN NAME First Middle Last Frances Bernadine Himmel			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16b SOCIAL SECURITY NO. 219-36-4789		17. INFORMANT Address Miss Frances Carlin 1900 S. Eads St. Arlington Va			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis							10 years
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gouty arthritis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 1948 , to May 28, 1969 , that (I) (we) last saw the deceased alive on May 9, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Fawcett				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/28/69	
22d. PHYSICIAN'S NAME (Type) JOHN Fawcett				22e. ADDRESS P.O. BOYDS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/31/69		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath.		23d. LOCATION (City or Town) (County) (State) Barnesville Montg. Md	
24. FUNERAL DIRECTOR William B. Wilton		ADDRESS Barnesville Md		25a. REC'D BY REGISTRAR DATE JUN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



4123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR P M	
CLARA BELLE CASHELL						5 24 69		4:20 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
FEMALE		WHITE		11/7/74		19 94			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		U.S.A.				MONTGOMERY Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
OLNEY			MONTGOMERY GEN. HOSP.			HOUSEWIFE		Home	
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. CITY OR TOWN			13c. STREET AND NUMBER		13d. CITY AND STATE	
MARYLAND			MONTGOMERY OLNEY			1301 Mass. Ave. NW		SHARON NURSING HOME	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Pletcher ERVIN			Elizabeth ANN Howes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
NO			218-54-6150		MEDICAL RECORDS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Asystole</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.H.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fractured R Hip</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
May 21/69		Fx of R Hip		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. May 18 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fell from chair May 18/69 Sharon Nursing Home</u>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING ETC) <u>Nursing Home</u>		21f. LOCATION Street or R.F.D. No City or Town County State <u>Ashton Md. MD</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 22</u> , 19 <u>69</u> , to <u>May 25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Lorenzo Marcolin</u>				22c. DATE SIGNED <u>5-26-69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Dr. Lorenzo Marcolin</u>				22e. ADDRESS <u>Rockville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/27/6		Mt. Carmel		Sunshine Mont. Md.			
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1-30

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07038 CERTIFICATE OF DEATH 07034									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR A. M.	
Elizabeth Virginia Cator						May 4 1969		4:20 P.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER YEAR MONTHS DAYS HOURS M N	
Female		White		January 19, 1911		58 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Washington D.C.		U.S.A. America				Montgomery		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington Sanitarium		Saleslady		Bakery			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INS DE CITY EMPLOY?		13e STREET AND NUMBER	
Maryland		Prince George		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3212 76th Avenue	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Lawrence Payne			Virginia Harrison						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address				
no			579 12 8925		Patient's chart				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus, Bronchial Pneumonia</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c LOCATION Street or R.F.D. No. City or Town County State					
21a		21b		21c					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1969, to <u>5-4</u> , 1969, that (I) (we) last saw the deceased alive on <u>5-2</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Stuart L. Nelson</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>5-4-69</u>		
22d PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>					22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		5/6/69		Ft. Lincoln		Colmar Manor P.G. Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a REG'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE			
Francis Gasch's Sons		Hyattsville, Md.		MAY 7 1969		<u>W. A. Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07039

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07035

1 DECEASED NAME (Type or Print) <i>William R</i>		First Middle Last		2a DATE KNOWN OF DEATH Month <i>May</i> Day <i>28</i> Year <i>1961</i>			2b HOUR Hour <i>2</i> Minute <i>15</i>	
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>10/31/1898</i>	6 AGE (In years last birthday) <i>70</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month <i>May</i> Day <i>28</i> Year <i>1961</i>
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Cathary</i>		3a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>11520 Lane Reserve Rd</i>
14 FATHER'S NAME <i>William R</i>		First Middle Last		15 MOTHER'S MAIDEN NAME <i>Elizabeth</i>		First Middle Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>217-46-5038</i>		17 INFORMANT <i>Shirley</i>		ADDRESS <i>Same as Mary Byrnes</i>		
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Lobar Pneumonia Acute.</i> <i>4124</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cardiovascular Disease.</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i> <i>years.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day, Year HOUR A.M. P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John S. Ball</i>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>May 28, 1961</i>		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>5-31-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>St Rose Cemetery</i>		23d LOCATION City or Town (County) (State) <i>Garthursburg, Montgomery Md</i>		
24 FUNERAL DIRECTOR <i>Ernest C. Gartner</i>		ADDRESS <i>Garthursburg, Md</i>		25a REC'D BY REGISTRAR <i>MIN 2 1969</i>		25b REGISTRAR'S SIGNATURE <i>William J. Gagne</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH	
NICOLA			CELENZA						Month Day Year	
3 SEX			4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		2b. HOUR	
MALE			W. H. F.		3/27/66		63 YRS		12:45 M	
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Italy			USA				Montgomery		Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Silver Spring			FILE SETTER			BUILDING	
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, LIM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Montgomery		Rockville		YES		4601 BACKWAY DR.	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last	
GENNARO			CELENZA							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT (Wife)		Address		Rockville, Md.	
NO			577-05-3890		MARY S. CELENZA		4601 BACKWAY DR.			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1890										
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
AORTIC VALVULAR DYSFUNCTION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 1966 to 1966, that (I) (we) last saw the deceased alive on 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph D. Connor MD						ATTENDING PHYS DEGREE		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) Joseph D. Connor						22e. ADDRESS 9420 Old Georgetown Rd., Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		May 13, 1969		Gate of Heaven Cemetery		Silver Spring, Montgomery, Md.				
Funeral Director Warner E. Pumphrey, Inc., 8434 Georgia Avenue						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
MAY 13 1969								James Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 13, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical examiner notified *J.R.*

Items 18 & 22a Film 413 6-2-69 ams										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07041										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07037	
1. DECEASED-NAME (Type or Print) First Middle Last JOHN HOWARD Chadwick,										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year 5-7 69 19				2b. HOUR 6:45 P							
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/17/25		6. AGE (in years last birthday) 44 YRS		IF UNDER 1 YEAR MONTHS DAYS 44		IF UNDER 24 HRS HOURS MIN 44		2c. DATE PRONOUNCED DEAD Month Day Year May 7 1969				2d. HOUR 6:45 P					
7a. BIRTH-PLACE (State or foreign country) New Jersey				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery				Md					
10. CITY OR TOWN OF DEATH Silver Spring, Md.				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sales Executive				12b. KIND OF BUSINESS OR INDUSTRY									
13a. JSJAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.				13b. COUNTY Howard				13c. CITY OR TOWN Laurel				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 11225 Martalini Dr.							
14. FATHER'S NAME First Middle Last John Howard Chadwick						15. MOTHER'S MAIDEN NAME First Middle Last Killian F. Bassett															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16b. SOCIAL SECURITY NO 11943-1946 144-18-2853						17. INFORMANT ADDRESS Mrs. Betty Chadwick 2512 11225 Martalini Dr.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary insufficiency 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE BELOEN R. REAP				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED May 7, 1969													
EXAMINER'S NAME (Type) BELOEN R. REAP				ADDRESS (Street, City, Town or County) 1400 W. Main																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 5/10/69		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery				23d. LOCATION (City or Town) (County) (State) Scaggsville Md											
24. FUNERAL DIRECTOR Canadon Funeral Home				ADDRESS Laurel Md				25a. RECEIVED BY REGISTRAR 19 1969				25b. REGISTRAR'S SIGNATURE Charles									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07042		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07038	
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
Lucille Stella CHRISTENSEN					May 21 69		615PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
Female		Caucasian		Nov. 3, 1904		64 YRS.	6 18
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Illinois		USA				Montgomery Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Naval Hospital		Housewife		N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Montgomery		Bethesda		13e. STREET AND NUMBER	
						10509 Montrose Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Henry Siegenthaler		Hedwick von Griebaun					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT			
No		219 48 5262		46 Horseshoe Rd. Address Guilford, Conn Mrs. Barbara O'Donnell, 46 Horseshoe Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intra cerebral hemorrhage							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (this hospital) attended the deceased from May 19, 1969, to May 21, 1969, that (I) (we) lost saw the deceased alive on May 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Evans Diamond, M. D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		May 23, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Evans Diamond, M. D.				Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5-26-69		Arlington National		Arlington Arlington Va.	
24. FUNERAL DIRECTOR				25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Federal Home				JUN 2 1969		[Signature]	
7557 Wisconsin Ave., Bethesda, Md.							

130X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH										07039	
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Henri deBalathier CLAIBORNE						May 5 1969			11:05 PM		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		
Male		Caucasian		Aug. 11, 1903			65 YRS		MONTHS DAYS HOURS M N		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md	
Louisiana		USA					Montgomery				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			U. S. Navy			Officer		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Virginia			Essex			Center Cross			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO		
Fernand Claiborne			Louise Villere			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			17 INFORMANT		
						1926 - 1947			Mrs. Harriot Claiborne, Center Cross, Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY										6 mos.	
IMMEDIATE CAUSE (a) Carcinoma of the Esophagus											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>											
22a. I certify that (X) (this hospital) attended the deceased from April 27, 1969, to May 5, 1969, that (X) (we) last saw the deceased alive on May 5, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)					
Mitchell Mills		6 May 1969				MITCHELL MILLS, CDR MC USN					
22e. ADDRESS		22f. ADDRESS									
Naval Hospital, Bethesda, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		5-8-69		Arlington National Cem.				Arlington, Virginia			
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey		May 12 1969				[Signature]					
7557 Wisconsin Ave., Bethesda, Maryland											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First DAVID			Middle —			Last CLUCK			2a. DATE OF DEATH Month Day Year 5 29 69			2b. HOUR 195		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 10-3-89			6. AGE (In years last birthday) 77 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) RUSSIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.								
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MERCHANT			12b. KIND OF BUSINESS OR INDUSTRY JEWELER								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MASS.			13b. COUNTY FALL RIVER, MASS			13c. CITY OR TOWN FALL RIVER, MASS			13d. CITY AND STATE FALL RIVER, MASS			13e. STREET AND NUMBER 638 WEETAMOE ST.					
14. FATHER'S NAME First Middle Last LAZAR — CLUCK			15. MOTHER'S MAIDEN NAME First Middle Last BLUMA HARRIS														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown) YES			16b. SOCIAL SECURITY NO. COOL 018-26-7844			17. INFORMANT 638 WEETAMOE ST FALL RIVER, MASS.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>69</u> , to <u>May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death																	
22b. SIGNATURE <u>[Signature]</u>			DEGREE ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5/29/1969								
22d. PHYSICIAN'S NAME (Type) BLAINE H. EIG			22e. ADDRESS 9401 Bergen Ave Silver Spring Md														
23a. BURIAL, CREMATION, REPOVAL (Specify) BURIAL			23b. DATE 6-1-69			23c. NAME OF CEMETERY OR CREMATORY NAT'L MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) FALLS CHURCH VA.								
24. FUNERAL DIRECTOR GOLDBERG FUNERAL HOME 4217 62nd St. N.W.			ADDRESS			25a. REC'D BY REGISTRAR JUN 2 1969			25b. REGISTRAR'S SIGNATURE [Signature]								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07045				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07041			
1 DECEASED NAME (Type or print) <i>Herrutha</i> First <i>—</i> Middle <i>—</i> Last <i>Cole</i>				2a. DATE OF DEATH Month <i>May</i> Day <i>29</i> Year <i>1969</i>				2b. HOUR <i>2:05</i> M			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>10/11/81</i>		6 AGE (In years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS <i>—</i> DAYS <i>—</i>		IF UNDER 24 HRS HOURS <i>—</i> MIN <i>—</i>	
7a BIRTHPLACE (State or foreign country) <i>MICHIGAN</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUA. OCCUPATION (Kind of work done during most of working life even if retired) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>101 Lucerne Lane</i>			
14 FATHER'S NAME First <i>ADELBERT</i> Middle <i>F.</i> Last <i>CHASE</i>		15 MOTHER'S M A DEN NAME First <i>FLORENCE</i> Middle <i>—</i> Last <i>Wilbur</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>no</i> (If yes give war or dates of service) <i>—</i>		16b SOCIAL SECURITY NO <i>220-44-7251</i>		17 INFORMANT Address <i>MRS. LEWIS DIESCHLER - SAME AS #13</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i> DUE TO, OR AS A CONSEQUENCE OF <i>—</i> (b) <i>Thromboembolism, spontaneous</i> DUE TO, OR AS A CONSEQUENCE OF <i>—</i> (c) <i>Pneumonia due to spinal injury the 10 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>—</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 days</i> <i>10 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Papillary muscle incompetence heart disease</i>											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <i>19</i> Month <i>—</i> Day <i>—</i> Year <i>—</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No <i>—</i> City or Town <i>—</i> County <i>—</i> State <i>—</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1956, to <i>5-29</i> , 1969, that (I) (we) last saw the deceased alive on <i>5-28</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Seruch T. Kimble</i> M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>5-29-69</i>							
22d. PHYSICIAN'S NAME (Type) <i>Seruch T. Kimble, M.D.</i>		22e ADDRESS <i>9801 S. 2nd St. Annapolis, Md</i>									
23a BURIAL, CREMATION REMOVAL (Specify) <i>Cremation</i>		23b DATE <i>6/2/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d LOCATION (City or Town) <i>Suitland, Maryland</i> (County) <i>—</i> (State) <i>—</i>					
24 FUNERAL DIRECTOR <i>Joseph Gawler's Sons</i>		ADDRESS <i>5130 Wis. Ave, Wash., D.C.</i>		25a REC'D BY REGISTRAR <i>UN</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
45M 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
07046											
07042											
1 DECEASED NAME (Type or print) First Middle Last EDITH W. COSGROVE						2a. DATE OF DEATH Month Day Year 5 8 69			2b. HOUR 3:30 PM		
3 SEX FEMALE		4 RACE CAUCASION		5. DATE OF BIRTH 7-18-88		6. AGE (In years last birthday) 87 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md					
10 CITY OR TOWN OF DEATH KENSINGTON		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) KEN. GAR. SAN.		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) SALES LADY		12b KIND OF BUSINESS OR INDUSTRY SALES					
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY WASHINGTON		13c CITY OR TOWN CONOCHESTER		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER ROUTE # 40			
14 FATHER'S NAME First Middle Last ALFRED WAGNER				15 MOTHER'S MAIDEN NAME First Middle Last Laura C. WARNER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NO 214-34-7618-7		17 INFORMANT SON		Address 49 E FRANKLIN HAGERSTOWN MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (his hospital) attended the deceased from 8/26, 1968, to 8/8, 1969, that (I) (we) last saw the deceased alive on 8/8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE [Signature]		22c PHYSICIAN'S NAME (Type) R.F. Kreuzburg		22d ADDRESS 2152 16th St NW Wash DC		22e DATE SIGNED 8/8/69		22f MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE 5/11/69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cem Hagerstown Md		23d LOCATION (City or Town) (County) (State)					
24 FUNERAL DIRECTOR A.E. Minnich Greencastle Pa		24b ADDRESS Per C.M. Stiller		25a REC'D BY REGISTRAR DATE MAY 12 1969		25b REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07047		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07043		
CERTIFICATE OF DEATH								
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A M
LeRoy			(None)	Covert	May 25 1969		1 20 A	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male	White	2 - 24 - 88		61 YRS				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
New York	U.S.	Montgomery			Md			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Takoma Park	Washington San. & Hosp		Retired - Gov't		U.S. Gov't.			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY L.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3a STREET AND NUMBER				
Maryland	Montgomery	Silver Spring	YES	8003 Eastern Avenue.				
4 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Last	
Anthony		Covert		Catherine		Townsend	Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
Yes		A.W.Z.		Myrtle R. Covert-8003 Eastern Ave., Takoma Pk.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism and/or								
DUE TO, OR AS A CONSEQUENCE OF (b) Left Sided Thrombosis 9 days								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Choking Myocardial infarction - 9 yrs								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Marked Emphysema 34 yrs								
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/18/69, to 5/25/69, that (I) (we) last saw the deceased alive on 5/24/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED		
Howard T. Morse						5/25/69		
22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f REGISTRAR'S SIGNATURE				
Howard T. Morse		7030 Carroll Ave Takoma Park Md		Charles Judge				
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		25a REC'D BY REGISTRAR		
Burial	May 28 1969	Fort Lincoln Cemetery		Bladensburg, Maryland		MAY 28 1969		
25b REGISTRAR'S SIGNATURE		25c ADDRESS		25d REGISTRAR'S SIGNATURE				
Warner E. Pumphrey, Inc., Silver Spring, Md.		8434 Georgia Avenue		Charles Judge				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07044

1. DECEASED-NAME (Type or Print) <i>William Murphy C. Davis III</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <i>May 11 1969</i>		2b. HOUR <i>10 P M</i>
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>8/4/22</i>	6 AGE (in years) <i>36</i> YRS	7c. DATE PRONOUNCED DEAD Month <i>May</i> Day <i>11</i> Year <i>1969</i>	7d. HOUR <i>12 15 M</i>
7a. BIRTHPLACE (State or foreign country) <i>Delaware</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Montgomery</i>		10. CITY OR TOWN OF DEATH <i>Montgomery</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>10690 Weymouth Ave</i>			
14. FATHER'S NAME First <i>Simon M</i> Middle <i>M</i> Last <i>Cravens</i>		15. MOTHER'S MAIDEN NAME First <i>Edna</i> Middle <i>H</i> Last <i>Cravens</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>528-34-6033</i>		17. INFORMANT <i>Mrs. Alison Cravens</i> ADDRESS <i>Alex., Va.</i>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Barbiturate poisoning</i> <i>7500</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Overdose of barbiturates</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>10:00 P M May 11, 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Took overdose of barbiturates</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Apartment</i>		21f. LOCATION Street or R.F.D. No City or Town County State <i>10690 Weymouth Ave. Bethesda Montg. Md.</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John B. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>May 13, 1969</i>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 16, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	
				23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>SE Davis</i>		ADDRESS <i>Cunningham Funeral Home, Inc. Alex., Va.</i>		25a. REC'D BY REGISTRAR <i>DATE MAY 15 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>John B. Bell</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 1-12 of Film 413
5-12-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07049

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07045

1 DECEASED NAME (Type or Print) ELOYCE CHRISTINA CRUICKSHANKS			2a DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 5-23-1969			2b HOUR M
3 SEX Female	4 RACE White	5 DATE OF BIRTH Mar. 2-1922	6 AGE (In years last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS 1 DAYS 1	# UNDER 24 HRS HOURS 1 MIN 00	2c DATE PRONOUNCED DEAD Month 5-23 Day 19 Year 69
7a BIRTHPLACE (State or foreign country) Brice Idaho		7b CITIZEN OF WHAT COUNTRY U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 516 Mississippi Ave.		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) promoter		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE Id.			13b COUNTY Montgomery	13c CITY OR TOWN Silver Spr.	13d RESIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 516 Mississippi Ave.
14. FATHER'S NAME Leroy Edwin Froom			15. MOTHER'S MAIDEN NAME Esther B. Froom			
16a WAS DECEASED EVER IN ARMED FORCES? (If yes give war or dates of service) No			16b SOCIAL SECURITY NO. _____		17 INFORMANT Leroy E. Froom #6 Graceville Rd. Silver Spring Md	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty metamorphosis of the liver 5/11/8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State		
22a. I certify that I took charge of the remains described above, held on death resulted from Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Belden R. Keap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED May 23, 1969
EXAMINER'S NAME (Type) BELDEN R. KEAP MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Blacksburg Rd. Silver Spring Md
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE May 1969		23c NAME OF CEMETERY OR CREMATORY St. Lincoln		23d LOCATION (City or Town) (County) (State) Blacksburg Rd. Silver Spring Md
24. FUNERAL DIRECTOR Arthur Walters			25a REC'D BY REGISTRAR May 27 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Gwendolyn Monier CRUMPACKER						May Month 13 Day Year 69		225A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		Caucasian		Sept. 13, 1910		58 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington, D.C.		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Naval Hospital		housewife		N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, J.M.T.S?		13e. STREET AND NUMBER	
Virginia		Arlington		Arlington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3717 North Nelson Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John Henry					BINSTED	Frances			SMITH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO			577-46-9428		St. Arlington, Va. Address RADM John W. CRUMPACKER, 3717 North Nelson				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Glioblastoma multiforme</u> <u>1929</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 14, 1969</u> to <u>May 13, 1969</u> , that (I) (we) lost saw the deceased alive on <u>May 13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Evans Diamond, M.D.</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED May 13, 1969		
22d. PHYSICIAN'S NAME (Type) <u>Evans Diamond, M.D.</u>					22e. ADDRESS Naval Hospital, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/15/69		Arlington National Cemetery		Arlington, Arlington, Va.			
24. FUNERAL DIRECTOR <u>Arlington Funeral Home</u> 3901 North Fairfax Drive, Arlington, Va.					25. RECEIVED BY REGISTRAR MAY 16 1969 DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07051

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07047

1 DECEASED NAME (Type or print) Blanche nore Crystal			2a DATE OF DEATH Month 5 Day 3 Year 69		2b HOUR 12:00
3 SEX F	4 RACE White	5 DATE OF BIRTH 7-15-1903		6 AGE (In years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) New York	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES NO <input type="checkbox"/>	13e STREET AND NUMBER 8500 New Hampshire Ave. S.S., Md
14 FATHER'S NAME First Middle Last Jasper			15 MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown No (If yes give war or dates of service)		16b SOCIAL SECURITY NO 109-03-4707		17 INFORMANT Address Joseph Crystal 8500 New Hampshire Ave. #315 Silver Spring, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from 3-17 , 19 68 , to 5-23 , 19 69 , that (I) (we) last saw the deceased alive on 5-1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Morton A. Itschuler				22c DATE SIGNED 5-23-69	
22d PHYSICIAN'S NAME (Type) Morton A. Itschuler, MD				22e ADDRESS 9205 New Hampshire Ave Silver Spring, Md	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE May 25, 1969		23c NAME OF CEMETERY OR CREMATORY King David Memorial Garden Falls Church, Virginia	
24. FUNERAL DIRECTOR Donald M. Stein		ADDRESS 232 Carroll		25a REC'D BY REGISTRAR MAY 27 1969	
25b REGISTRAR'S SIGNATURE Charles Judge					
Hebrew Memorial Funeral Home, St., N.W. Wash., D.C.					

4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07052

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07048

1. DECEASED NAME (Type or print) JOHN HERBERT CUFF			2a. DATE OF DEATH Month 5 Day 19 Year 69			2b. HOUR 3:10 P.M.	
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 12-11-79		6 AGE (In years last birthday) 89 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH OLNEY		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY STORE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ASHTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER -		14. FATHER'S NAME First MARTIN Middle - Last CUFF		15 MOTHER'S MAIDEN NAME First MARTHA Middle - Last Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO (If yes give year or dates of service) 217-32-2042		17. INFORMANT Address MEDICAL RECORD DEPT.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerotic cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 wks 15 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 59 , to 1969 , that (I) (we) last saw the deceased alive on May 18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. D. Bonifant				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.				22e. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-23-69		23c. NAME OF CEMETERY OR CREMATORY Burtonville Union		23d. LOCATION (City or Town) (County) (State) Burtonville Mont. Md.	
24 FUNERAL DIRECTOR NAME (Type) Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR MAY 22 1969	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113
30M REV 1-68

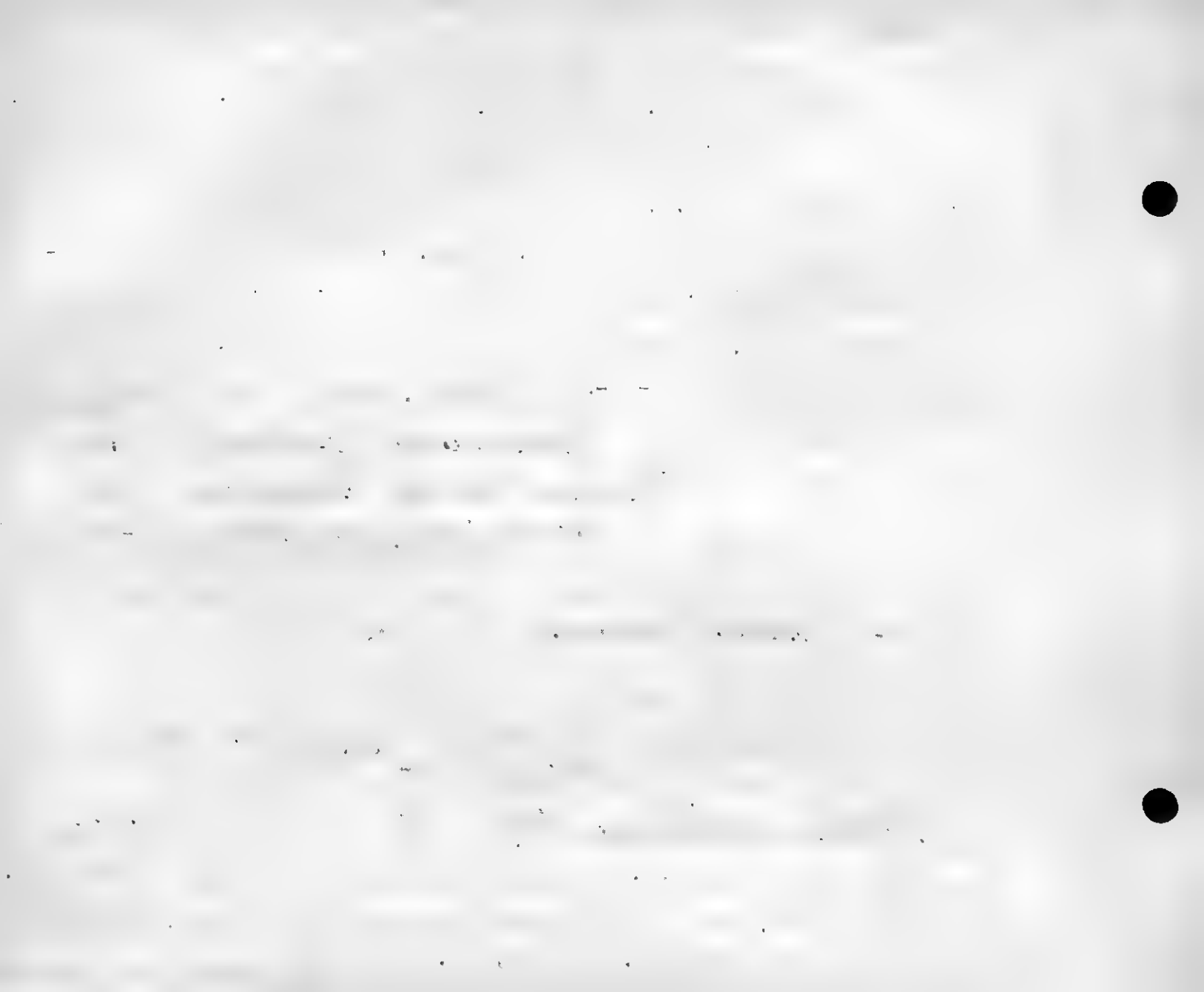
07053

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07049

1. DECEASED-NAME (Type or print) Alexine P. David			2a. DATE OF DEATH May Month 11 Day 1969 Year			2b. HOUR 5:20 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH May 14 1917		6 AGE (In years last birthday) 51 YRS	
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 5716 31st Avenue		14 FATHER'S NAME First Middle Last Donald F. Pence		15. MOTHER'S MAIDEN NAME First Middle Last Ila --- Boggan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 248-103786		17 INFORMANT William G. David		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Cranial Hemorrh. DUE TO, OR AS A CONSEQUENCE OF (b) Rupture Cerebral Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Status post Craniotomy							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 d. 4 d. 4 d.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 5-7-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral Aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-4 , 19 69 , to 5-11 , 19 69 , that (I) (we) last saw the deceased alive on 5-10 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jonathan McWilliams M.D.				22c. DATE SIGNED 5-11-69			
22d. PHYSICIAN'S NAME (Type) J. Williams M.D.				22e. ADDRESS 4835 Broad Brook Dr. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/13/1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland	
24. FUNERAL DIRECTOR Nalley's Funeral Home Mt. Rainier, Md.				25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. at least prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

4109

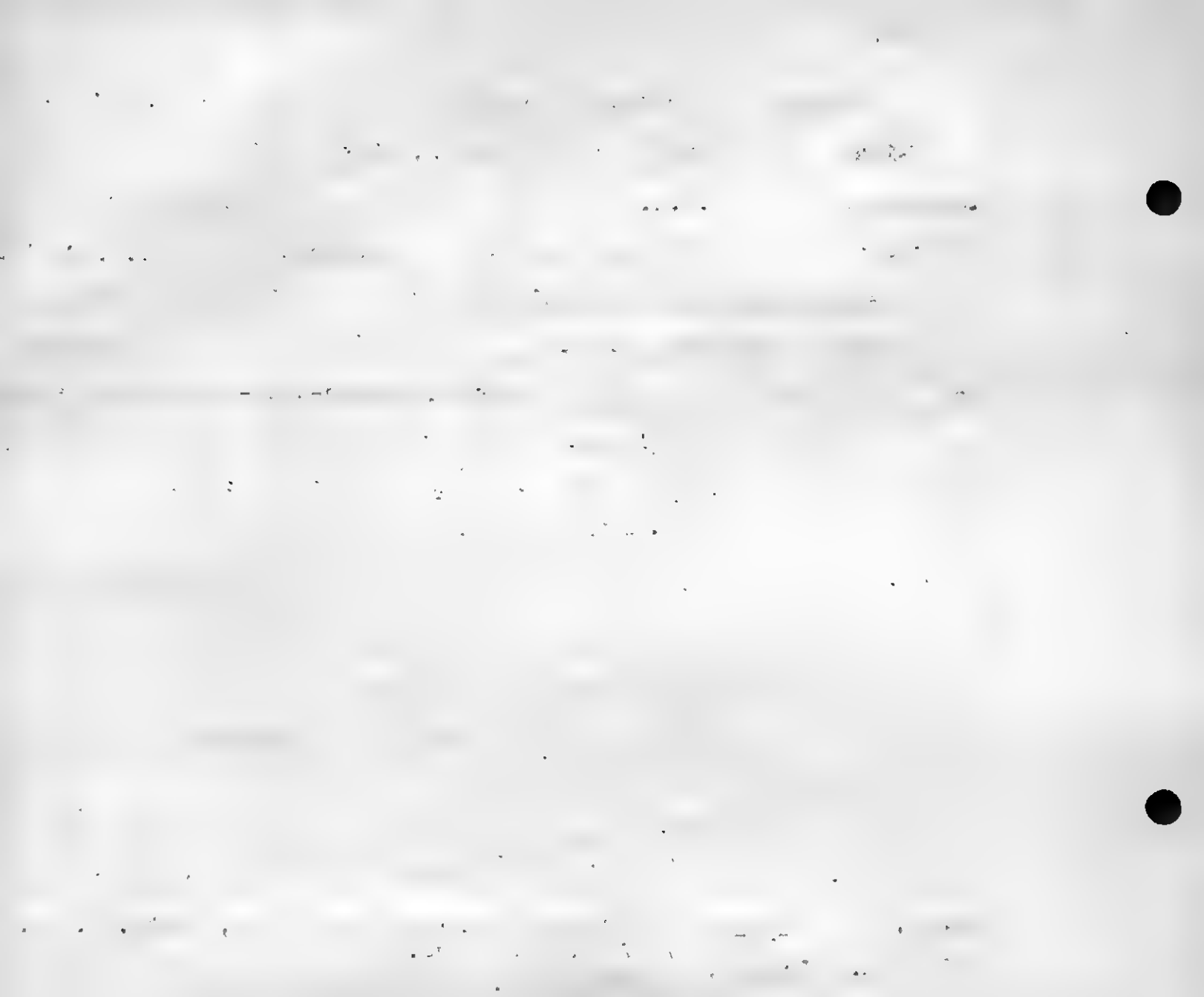
07054

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07050

1 DECEASED NAME (Type or print) EUGENE COWAN DENSON			2a DATE OF DEATH Month May Day 29 Year 1969		2b HOUR 1 A M
3 SEX Male XXXX	4 RACE White	5 DATE OF BIRTH May 12, 1906		6 AGE (In years lost birthday) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Mississippi	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6208 Redwing Road		12a USUAL OCCUPATION (Kind of work done during most of work n g life, even if retired) Employee	
13a USUAL RES DENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 6208 Redwing Road
14 FATHER'S NAME First Middle Last Eugene Grisham Denson			15 MOTHER'S MAIDEN NAME First Middle Last Julia McInnis		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ****		16b. SOCIAL SECURITY NO. 579-42-8019	17. INFORMANT Address Helen W. Denson-Wife- Address as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF suddenly (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF with coronary sclerosis (c) with coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Had an acute myocardial infarction Feb 22, 1968					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a I certify that (I) (this hospital) attended the deceased from 1949 , 19 1949 , to May 23 1969 , that (I) (we) last saw the deceased alive on May 23 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE C P Ryland		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c DATE SIGNED 5-29-69		
22d PHYSICIAN'S NAME (Type) 4400-49 ST NW Washington DC 20066 C.P. RYLAND		22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 5-31-69	23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montg. Co. Md.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY,		7557 Wisconsin Ave Bethesda, Md.		25a REC'D BY REGISTRAR DATE JUN 5 1969	25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) <i>William T Diefenbach</i>		2a DATE OF DEATH Month <i>May</i> Day <i>25</i> Year <i>1969</i>		2b. HOUR <i>10:40 PM</i>	
3 SEX <i>male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>9/12/1892</i>	
7a BIRTHPLACE (State or foreign country) <i>New York</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Suburban Hosp.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Chemist</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Cherry Chase</i>	
14 FATHER'S NAME First <i>William</i> Middle <i>Diefenbach</i> Last <i>Thilomena</i>		15 MOTHER'S M A DEN NAME First <i>Servatius</i> Middle <i>Servatius</i> Last <i>Servatius</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give year or dates of service) <i>****</i>	
16b. SOCIAL SECURITY NO <i>050-03-2698</i>		17 INFORMANT <i>Son & Wife</i>		Address <i>Same</i>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY <i>4109</i> IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>many years</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>68</i> , to <i>May</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>May 6</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>Allen J. O'Neill MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		22c. DATE SIGNED <i>5/25/1969</i>			
22e. ADDRESS <i>8601 Old Georgetown Rd, Bethesda MD</i>					
23a. BURLA, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>5-28-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	
23d. LOCATION (City or Town) <i>Suitland, Pr. Geo. Md.</i>		(County)		(State)	
24 FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		7557 Woodson Ave		25a. REC'D BY REGISTRAR <i>JUN 2 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>Phyllis Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07056		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07052	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print)		First John		Middle (Rendleton) Pedleton		Last DUCKETT	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH May 26, 1925		2a. DATE OF DEATH May 25 1969 6:15 PM	
7a. BIRTHPLACE (State or foreign country) Wash. D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) U.S. Navy		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) STATE Virginia		13b. COUNTY Alexandria		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 316 Lamond Place	
14. FATHER'S NAME First Edmund		Middle DuVal		Last DUCKETT		15. MOTHER'S MAIDEN NAME First Eliza	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service) 1946-68		16b. SOCIAL SECURITY NO.		17. INFORMANT Virginia		Address Mrs. Eliza Duckett, 2419 King St. Alexandria	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Glioblastoma multiforme</u> 1929 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (if this hospital) attended the deceased from <u>Oct. 2, 1968</u> , to <u>May 25, 1969</u> , that (we) lost saw the deceased alive on <u>May 25, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>Lawrence J. Mervis, M.D.</u>				22c. DATE SIGNED May 27, 1969		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (Type) Lawrence J. Mervis, M.D.				22f. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/28/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.	
24. FUNERAL DIRECTOR Home, Alexandria, Virginia				25a. REC'D BY REGISTRAR DATE MAY 29 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07057

07053

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or Print) <i>Elizabeth M. Dungen</i>			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <i>5</i> Year <i>1969</i>			2b. HOUR <i>10:40 A.M.</i>
3 SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>3-7-81</i>	6 AGE (in years last birthday) <i>88</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i> MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>May</i> Day <i>31</i> Year <i>1969</i>
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <i>Robert</i> Middle <i>Dixon</i> Last <i>Dixon</i>		15. MOTHER'S MAIDEN NAME First <i>Mary Jane</i> Middle <i>McGuire</i> Last <i>McGuire</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		
16b. SOCIAL SECURITY NO. <i>215-54-7152</i>		17. INFORMANT <i>Franklin Garrison - Silver Spring</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden - years.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>Fracture - Left Humerus + Left Hip</i>						
19a. DATE OF OPERATION <i>May 23 69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Repair of Fracture - Hip</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>5/19 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell in nursing home</i>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Nursing Home</i>		21f. LOCATION Street or R.F. No. City or Town County State <i>2101 Fairland Rd Silver Spring Mont. Md.</i>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John S. Ball</i>		EXAMINER'S NAME (Type) <i>John S. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS. STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>May 31, 1969</i>
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-3-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Melrose</i>		23d. LOCATION (City or town) (County) (State) <i>Northumberland Va.</i>
24. FUNERAL DIRECTOR <i>Sanford's Home Mortuaries etc</i>		ADDRESS <i></i>		25a. REC'D BY REGISTRAR DATE <i>JUN 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Dodge</i>

07058

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07054

1. DECEASED-NAME (Type or print) <i>E. Myrtle Dunnebacke</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>26</i> Year <i>1969</i>			2b. HOUR <i>11:45</i> P.				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>12/23/89</i>		6. AGE (In years last birthday) <i>79</i> YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Michigan</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md				
10. CITY OR TOWN OF DEATH <i>Olney</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brooke Grove Foundation</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>405 Ellsworth Drive</i>	
4. FATHER'S NAME First <i>George</i> Middle <i>Gauthier</i> Last <i>Linnea</i>			15. MOTHER'S M A DEN NAME First <i>Amnesse</i> Middle <i>Amnesse</i> Last <i>Amnesse</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Francis G. Dunnebacke-405 Ellsworth Dr., Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ACHEXIA - GENERALIZED</i>									<i>6 Mo</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CEREBRAL ARTERIOSELEPOSIS</i>									<i>2 Yrs</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>GENERALIZED ARTERIOSELEPOSIS</i>									<i>YES</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>NONE</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <i>FEB 1968</i> , to <i>26 May 1969</i> , that (I) (we) last saw the deceased alive on <i>26 May 1969</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Ronald F. Lewis M.D.</i>			DEGREE <i>M.D.</i>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>27 May 69</i>		
22d. PHYSICIAN'S NAME (Type) <i>D. R. LEWIS M.D.</i>			22e. ADDRESS <i>700 CLOVERLY ST SIL SPR MD.</i>							
23a. BURIAL, CREMATION (REMOVABLE SPECIFY) <i>Burial</i>			23b. DATE <i>May 31, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Catholic Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Marquette, Michigan</i>			
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>			ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>			25a. REC'D BY REGISTRAR <i>JUN 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

07059		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07055	
1 DECEASED NAME (Type or print)		First Elsie	Middle M.	Last Durand	2a DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1969</u>		2b HOUR <u>5:15</u> AM
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH 8-22-1880			6 AGE (in years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? United States	8 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				Md.
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Manor Nursing Home		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) At Home		12b KIND OF BUSINESS OR INDUSTRY -		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Dist. of Col.	13b COUNTY -	13c CITY OR TOWN Washington	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 2122 California At. N.W.			
14 FATHER'S NAME First Watson Middle Cline Last Clevenger	15 MOTHER'S MAIDEN NAME First Emma Middle Clevenger Last Clevenger						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (+ yes give war or dates of service)	16b SOCIAL SECURITY NO 578-6049059	17 INFORMANT St. M.W., Wash., D.C. Mrs. Mildred McCormick, Daughter, 2122 Calif.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4125</u> Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> 6 years DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> years?							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>63</u> , to <u>May 6</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>May 3</u> , 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Neil P. Campbell</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>5/6/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u>				22e. ADDRESS <u>1629 Cal Rd</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5-9-1969	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co. Md.		
24 FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.				25a REC'D BY REGISTRAR DATE MAY 8 1969		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last Joseph W Eason			2a. DATE KNOWN OF DEATH ESTIMATED			2b. HOUR
3 SEX Male			4 RACE White		5. DATE OF BIRTH 1-25-40		6. AGE (In years last birthday) 29 YRS		12:45 PM
7a. BIRTHPLACE (State or foreign country) Montgomery Co Md			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Takoma Pk			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7321 Carroll Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Lab. Technician			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to STATE) Maryland			13b. CITY OR TOWN Montgomery			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 7321 Carroll Ave
14. FATHER'S NAME First Middle Last O. Z. Eason			15. MOTHER'S MAIDEN NAME First Middle Last Kettie Jones			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b. SOCIAL SECURITY NO.			17. INFORMANT (Name) Mrs. Kettie Eason			ADDRESS 607-Ray St. Beltsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to DUE TO, OR AS A CONSEQUENCE OF (b) Hanging, self-inflicted DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					21b. TIME OF INJURY Month, Day, Year 11-5-14-69				
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased hanging self from pipe in basement using belt from pants					21d. LOCATION Street or R.F.D. No. City or Town County State 7321 Carroll Ave, TPK, Montgomery Md				
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					22b. DATE SIGNED MAY 14 1969				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE May 18-1969				
23c. NAME OF CEMETERY OR CREMATORY Brooklyn Family					23d. LOCATION (City or Town) County (State) Beltsville, Md. Montgomery Md				
24. FUNERAL DIRECTOR (Name) Arthur Tatters					25. REC'D BY REGISTRAR DATE MAY 19 1969				
26. REGISTRAR'S SIGNATURE Charles Judge									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

117003

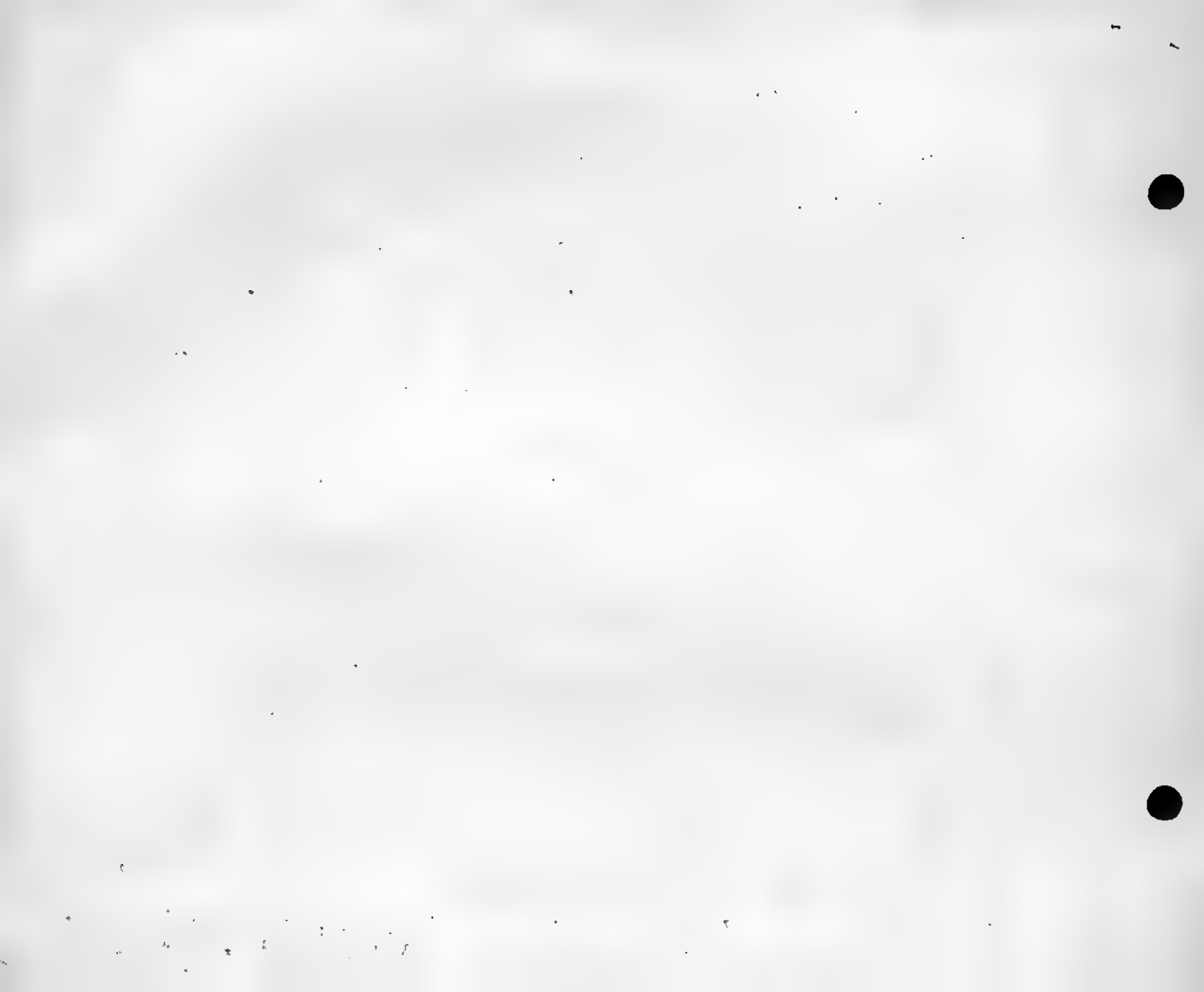
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07057

Item#16bFilm#G412

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <i>Norman Kenneth Ebbs Jr</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5 16 1969			2b. HOUR 8 30 M		
3 SEX <i>male</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>5/14/34</i>	6 AGE (n years) <i>35</i> YRS	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <i>May 16 1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Hartford Conn</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Oceanographer</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. STREET AND NUMBER <i>1912 Stedwick Dr.</i>		
14. FATHER'S NAME First Middle Last <i>Norman Kenneth Ebbs</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Jessie W Wirth</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Korean</i>			16b. SOCIAL SECURITY NO. <i>047-445 30-0933</i>			17. INFORMANT ADDRESS <i>53 Ridgecroft W. Hartford Conn</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>ASphyxia-</i> <i>1520</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <i>Carbon Monoxide Inhalation.</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>8 15 PM 5/16 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>run engine fixed - how to exhaust pipe to rear of car</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Street</i>		21f. LOCATION Street or R.F.D. No City or Town County State <i>Blunt Rd. & Neallsville Church Rd. Gaithersburg, Mont. Md.</i>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED - <i>May 16, 1969</i>		
EXAMINER'S NAME (Type) <i>John G Ball</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county) <i>Bethesda, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 19, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Soldiers Field Fairview Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>West Hartford Conn.</i>		
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>				7557 Wisconsin Ave <i>Bethesda, Md</i>		25a. READ BY REGISTRAR <i>May 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



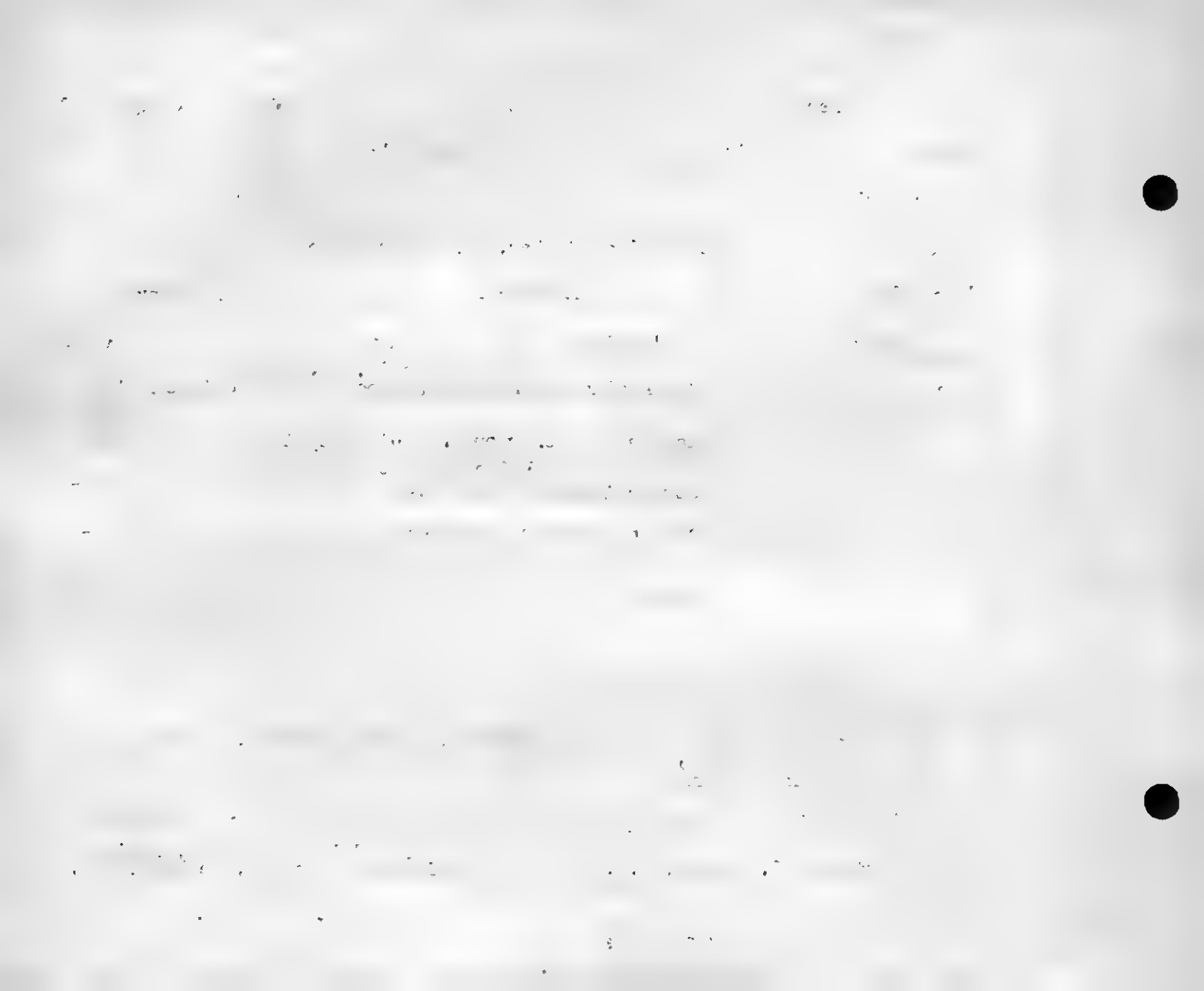
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove separator papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A		
Eileen			Eddy			May 3 1969		3:15 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (n years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		5 March 1911		58 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Missouri		USA				Montgomery		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center, NIH			Housewife				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY J.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Virginia			Alexandria		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5325 Polk Avenue			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Edgar O'Daniel			Ruth Ritter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT					
No			Not Available		Bethesda, Md. 20014 Address The Medical Records, The Clinical Center					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia with Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Shock Secondary to (A) and to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Retroperitoneal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myelogenous Leukemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Hours-Days 4/7 - 5/2										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, etc.) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from April 7, 1969, to May 3, 1969, that (we) saw the deceased alive on May 3, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.										
22b. SIGNATURE Richard J. Samaha MD					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 3 May 1969			
22d. PHYSICIAN'S NAME (Type) Richard J. Samaha, M.D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/4/69		Cedar		Suitland, Md.				
24. FUNERAL DIRECTOR Greene Funeral Home, Alexandria, Va.					25a. REC'D BY REGISTRAR DATE MAY 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



1829

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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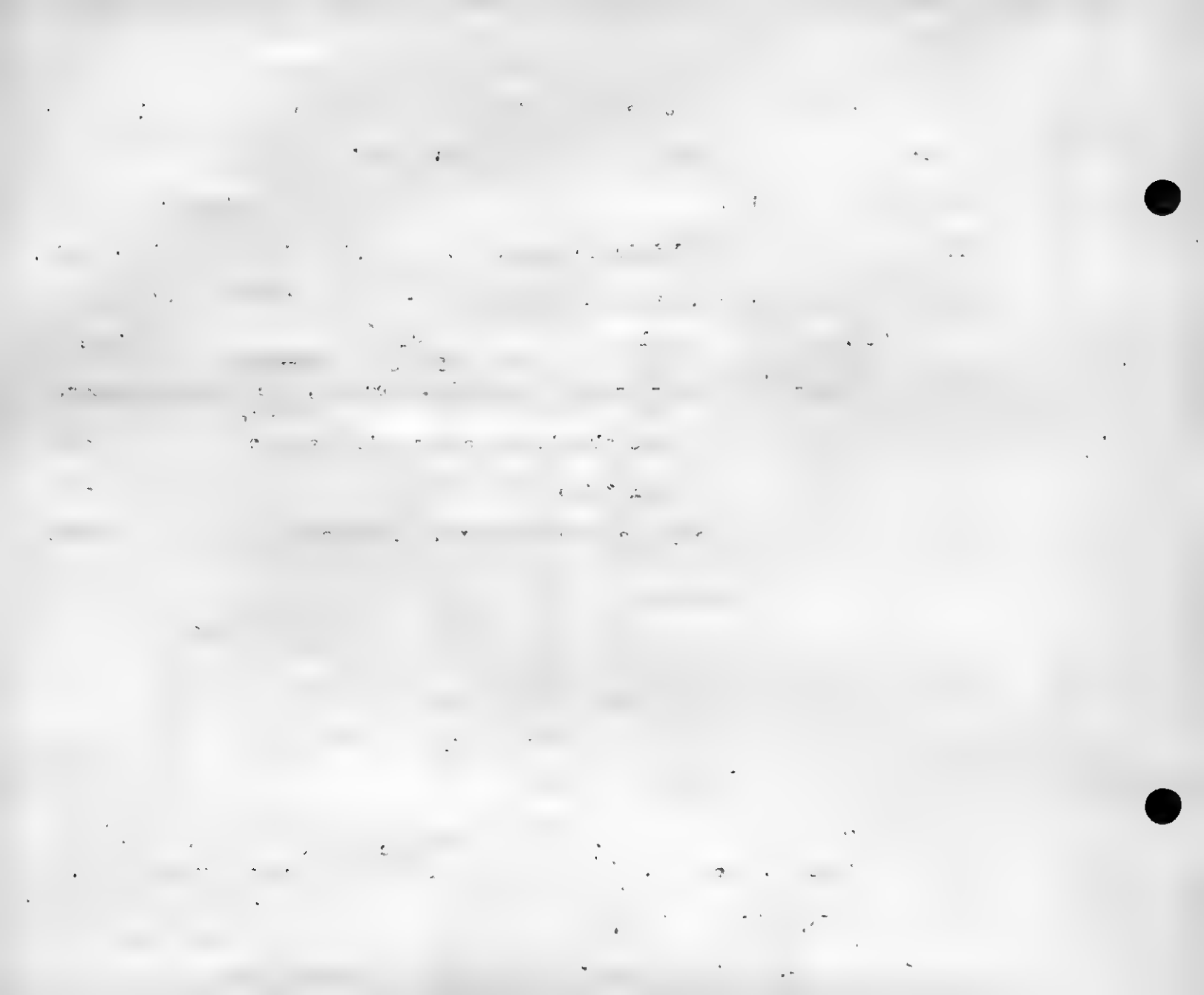
07063		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07059	
Item 111 Film 413 6/11/69 kk					
1. DECEASED NAME (Type or print) MAMIE ELOIS ELLIOTT			2a. DATE OF DEATH Month MAY Day 30 Year 1969		2b. HOUR 11:58 PM
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 19, 1902		6. AGE (In years last birthday) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10927 Bucknell Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY —
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN Silver Sp.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 10927 BUCKNELL DR. SILVER SP.	
14. FATHER'S NAME First WILLIAM Middle DUKE Last DUKE	15. MOTHER'S MAIDEN NAME First MAMIE Middle TITUS Last TITUS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) NONE		
16b. SOCIAL SECURITY NO. 223-01-0302		17. INFORMANT BURNELLE SORENSON		Address 1111 ARMY-NAVY DR ARL VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus (cervix) 180X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town. County State			
22a. I certify that (I) (this hospital) attended the deceased from January, 1969 , to May 30, 1969 , that (I) (we) lost saw the deceased alive on May 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Blaine H. Eick	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED May 30, 1969		
22d. PHYSICIAN'S NAME (Type) BLAINE H EICK	22e. ADDRESS 9801 Derrin Ave Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE JUNE 3, 1969	23c. NAME OF CEMETERY OR CREMATORY MAPLE VIEW CEM.	23d. LOCATION (City or Town) (County) (State) MARION KY		
24. FUNERAL DIRECTOR IVES FUNERAL HOME		25a. REC'D BY REGISTRAR JOHN 5 1969		25b. REGISTRAR'S SIGNATURE William J. Jones	
26. FUNERAL HOME ADDRESS 2847 WILSON BLVD ARL VA.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VRA 15 (4)
30M REV 1-66

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07064 CERTIFICATE OF DEATH 07060									
1 DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR AM PM
Harold			Joseph	Elser		May 2 1969			3:25 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		6 August 1907		61 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wisconsin		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Biologist		City Gov't.	
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Edgewater		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Route 3, Box 101
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Last
George			Elser			Ella			Fisher
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
Yes			1942-1945		Bethesda, Maryland				
			399-07-6038		The Medical Records, The Clinical Center,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF <u>Congestive heart failure with cardiac/</u> <u>arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lymphosarcoma (Widespread metastasis)</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days 8 Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:(c)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <u>Dr. David A. Bray</u> (this hospital) attended the deceased from <u>21 April</u> , 19 <u>69</u> , to <u>2 May</u> , 19 <u>69</u> , that <u>we</u> (we) last saw the deceased alive on <u>2 May</u> , 19 <u>69</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>David A. Bray, MD.</u>		22c. DATE SIGNED <u>2 May 1969</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)			
Burial		5/5/69		Baltimore Nat'l		Baltimore Md			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE <u>6-19-69</u>			
<u>Robert S. Benavente</u>		<u>Severna Park</u>		<u>Severna Park</u>		<u>Robert S. Benavente</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07065

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07061

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Harry Vernon Embrey Jr.								Month Day Year May 6 1969		8:30 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	7 FINDER MONTHS		8 YEAR		9 UNDER 24 HRS		10 HOUR
male	white	Jan. 25, 1919		50 YRS	3		11		12		1 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH		Md	
Maryland		U. S. A.		WIDOWED		DIVORCED		Montgomery			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital		Mechanic							
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission), STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Montgomery		Whitehat		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4507 Bayne St.			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Harry Vernon Embrey Sr.								Lottie Burroughs			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
Yes		1942-1945		220072093		Harry V. Embrey, Sr. father same # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema, acute										Sudden	
5/10 DUE TO, OR AS A CONSEQUENCE OF (b) Acute fatty metamorphosis, liver											
DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholism, acute and chronic										Years.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
John G. Ball								May 7, 1969			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER							
John G. Ball				17936 Old Georgetown Road, Bethesda, Montgomery, Md.							
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		5/9/69		Parklawn Cemetery		Rockville, Maryland					
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Tyson Wheeler				1331 Rockville Pike Rockville, Maryland				MAY 9 1969			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07066

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07062

1. DECEASED-NAME (Type or Print) KIMBERLY			First DEAN Middle EVY Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 05 Day 12 Year 69			2b. HOUR M						
3 SEX Female		4 RACE Wh.		5 DATE OF BIRTH 02/17/69		6. AGE (in years last birthday) 7- YRS 3- MONTHS 7- DAYS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 5 Day 12 Year 69		2d. HOUR 10:55 AM			
7a. BIRTHPLACE (State or foreign country) Wash, DC				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) xxxxxxx minor				12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USLA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.				13b. COUNTY Montgomery				13c. CITY OR TOWN Burntsville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Roger Middle Eugene Last Evy				15. MOTHER'S MAIDEN NAME First Joe Middle Anne Last Day				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none				16b. SOCIAL SECURITY NO. ---			
17. INFORMANT Father, Roger				ADDRESS 3510 Fairland Rd, Brtnsvl.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiorespiratory Failure				DUE TO, OR AS A CONSEQUENCE OF (b) Cause Undetermined				DUE TO, OR AS A CONSEQUENCE OF (c) Crib Death (SUDI)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>		and in my opinion	
ACTUAL SIGNATURE Belden R. Keap				M.D. BELDEN R. KEAP M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED May 12, 1969			
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.				ADDRESS (Street, City, Town or county) 254 Carraway NW HC				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. BURIAL CREMATION REMOVAL (Specify) Burial				23b. DATE May 14, 1969				23c. NAME OF CEMETERY OR CREMATORY National Memorial Park				23d. LOCATION (City or Town, County, State) Falls Church, Virginia			
24. FUNERAL DIRECTOR Arthur Walters				ADDRESS 254 Carraway NW HC				25a. REC'D BY REGISTRAR MAY 14 1969				25b. REGISTRAR'S SIGNATURE ---			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07067

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07063

1 DECEASED NAME (Type or print) Habry Francis Fancher			First Middle Last			2a DATE OF DEATH May Month 20 Day 1969 Year			2b. HOUR 3:08 P.M.					
3 SEX Male			4 RACE White			5 DATE OF BIRTH August 8, 1890			6 AGE (In years last birthday) 78 YRS.					
7a BIRTHPLACE (State or foreign country) Connecticut			7b CITIZEN OF WHAT COUNTRY? America			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Takoma Park			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FOREMAN - NAVY YARD - U.S. GOV'T.			12b KIND OF BUSINESS OR INDUSTRY					
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington D.C.			13b COUNTY D.C.			13c CITY OR TOWN D.C.			13d INSIDE CITY LIM IT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13e STREET AND NUMBER 4118 3rd Street, NW			14 FATHER'S NAME Asa F Fancher			15 MOTHER'S MAIDEN NAME Margaret Tuttle			15b MOTHER'S MAIDEN NAME Tuttle					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no			16b SOCIAL SECURITY NO (If yes give war or dates of service) 069-05-8698			17 INFORMANT Elizabeth J. Fancher (Wife) same as above			17b ADDRESS same as above					
18 CAUSE OF DEATH (Enter only one cause per one for (a) (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from <u>May 15</u> , 1969, to <u>May 20</u> , 1969, that (I) (we) last saw the deceased alive on <u>May 19</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE Arthur J. Wilets						DEGREE ATTENDING PHYS			MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED May 20, 1969		
22d PHYSICIAN'S NAME (Type) Arthur J. Wilets						22e ADDRESS 1111 Spring, St. Silver Spring, Maryland								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE May 23, 1969			23c NAME OF CEMETERY OR CREMATORY George Washington Cemetery			23d LOCATION (City or Town) (County) (State) Hyattsville, Maryland					
24 FUNERAL DIRECTOR'S NAME (Type) P. J. Smith, Inc., Silver Spring, Maryland Warner E. Pumphrey, Inc., 8434 Georgia Avenue						25a REC'D BY REGISTRAR MAY 26 1969			25b REGISTRAR'S SIGNATURE Charles Judge					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

07068

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07064

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR			
Morris Feinstein								5-26-69		19						9:55 P.M.			
3 SEX	M	4. RACE	W	5. DATE OF BIRTH	9-18-15		6 AGE (In years last birthday)	53 YRS	IF UNDER 1 YEAR		MONTHS		DAYS		IF UNDER 24 HRS		HOURS		
7a. BIRTHPLACE (State or foreign country)		penn.		7b. CITIZEN OF WHAT COUNTRY?		U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Montgomery				2c. DATE PRONOUNCED DEAD		Month	
10 CITY OR TOWN OF DEATH		Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY		Stautenberg		2d. HOUR		9:55 P.M.	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		Md.		13b. COUNTY		Mont.		13c. CITY OR TOWN		S. S.		13d. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		1220 Eastwest Hwy.	
4 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last					
Abraham Feinstein								Sarah --											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17 INFORMANT		Hannah Feinstein, wife, S.S., Md.		ADDRESS		1220 E.W. Hwy					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19		DUE TO, OR AS A CONSEQUENCE OF		Acute Coronary Insufficiency		DUE TO, OR AS A CONSEQUENCE OF		(b) Coronary Artery Heart Disease		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		May 27, 1969					
EXAMINER'S NAME (Type)		BELOEN R. REAP, M.D.		ADDRESS (Street, city, town, county)															
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE		5/28/69		23c. NAME OF CEMETERY OR CREMATORY		Bnai Israel Cong. Cem.		23d. LOCATION (City or Town)		Oxon Hill, Md.					
24 FUNERAL DIRECTOR		Bernard Danzansky & Sons		ADDRESS		3501 14th St. NW Wash., D.C.		25a. REC'D BY REGISTRAR		DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE		J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07069

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07065

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Francis Marion Fenwick			2a. DATE OF DEATH Month May Day 3 Year 1969		2b. HOUR 2:35 P.M.
3 SEX Male	4 RACE White	5. DATE OF BIRTH 5/8/14		6 AGE (In years lost birthday) 54 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Mont. Co.		
10. CITY OR TOWN OF DEATH Sil. Spg. Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FOREMAN	12b KIND OF BUSINESS OR INDUSTRY Tool & Auto. Firm		
13a USAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.	13b COUNTY Mont.	13c CITY OR TOWN Wheaton	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3113 Medway St.	
14 FATHER'S NAME First Joseph Middle A. Last Fenwick		15 MOTHER'S MAIDEN NAME First Mattie Middle Connelly Last Connelly			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no	(If yes give war or dates of service)	16b SOCIAL SECURITY NO 577-03-8844	17 INFORMANT Address Mrs. Margaret Fenwick, 3113 Medway Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, gastric DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma throat DUE TO, OR AS A CONSEQUENCE OF (c) Gastric ulcer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 mos. 9 mos.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from July , 19 58 , to May 3 , 19 69 , that (I) (we) lost saw the deceased alive on May 2 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE A.W. Smith M.A.				22c. DATE SIGNED 5/3/69	
22d. PHYSICIAN'S NAME (Type) A.W. SMITH		22e. ADDRESS 13018 GEORGIA AVE WHEATON, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE May 6, 1969	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or Town) (County) (State) Switland, Maryland		
24. FUNERAL DIRECTOR Paul Smith		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. RECD BY REGISTRAR DATE 7 1969	25b REGISTRAR'S SIGNATURE Carroll

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

07070

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07065

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Thomas nmn FERRARO			2a. DATE OF DEATH Month 5 Day 8 Year 69			2b. HOUR 2:45 AM					
3 SEX Male		4 RACE Caus		5 DATE OF BIRTH 4/7/84		6 AGE (in years last birthday) 85 YRS.		7 UNDER 1 YEAR MONTHS 1 DAYS 1		8 UNDER 24 HRS HOURS 1 MIN 1	
7a BIRTHPLACE (State or foreign country) Italy			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Wheaton, Md			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home University Nursing			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Brick layer			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE DC			13b COUNTY Washington			13c CITY OR TOWN Washington			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 509 Massachusetts Ave NW			14 FATHER'S NAME First FERRARO Middle Un Last KNOW			15 MOTHER'S M A DEN NAME First Un Middle KNOW Last KNOW					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Nursing Home Records - Wheaton, Mo.			Address		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) probable myocardial infarction 4177 DUE TO, OR AS A CONSEQUENCE OF generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No 69 City or Town Quincy County 69 State 69					
22a. I certify that (I) (this hospital) attended the deceased from Quincy , 19 69 , to Quincy , 19 69 , that (I) (we) last saw the deceased alive on May 19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David A. Morawitz						DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED May 1969		
22d. PHYSICIAN'S NAME (Type) DAVID A. MORAWITZ MD						22e. ADDRESS 9237 Three Oaks Drive, Silver Sp Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE MAY 10, 1969			23c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL Cemetery			23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.		
24. FUNERAL DIRECTOR James E. Nyson						ADDRESS Wash. D.C.			25a. REC'D BY REGISTRAR MAY 12 1969		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Helen DELORES			Finch			Month Day Year			3:30AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		CAUCASIAN		7-11-24		44 YRS. 10			
7a BIRTHPLACE (State or foreign country)		7b CIT. ZEN OF WHAT COUNTRY?		B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MD		U.S.A.				Montgomery			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INST. TUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. K. NO. OF BUSINESS OR INDUSTRY			
Kensington		3000 McComas Ave		Housewife					
3a. USAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD		Mont		Rockville				13313 VANDALIA DR	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Calvin Wolfe			GRAY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
no		577-26-1351		Lorenzer J. D. Finch, Sr. Husband same					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Failure coronary artery disease</u>									2.46.0
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple sclerosis</u>									6 years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item #8)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/1/65, 19, to 5/5, 1967, that (I) (we) lost saw the deceased alive on 4/30/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Patrick C. Jameson		5/5/67							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Patrick C. Jameson		11718 Georgia Silver Spring Md							
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/19/69		Parklawn		Rockville, Montg. Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Tyson Wheeler Funeral Home Rockville, Md.		MAY 19 1969		Charles Judge					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07068

07072

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) <i>Calvin Harvey Fitz Sr.</i>		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <i>May 4</i> 19 <i>69</i>		2b HOUR <i>10:00</i> AM
3 SEX <i>M</i>	4 RACE <i>Negro</i>	5 DATE OF BIRTH <i>Feb. 14-24</i> 19 <i>45</i> YRS	6 AGE <i>24</i> YRS	7c MONTHS <i>10</i> MONTHS
7a BIRTHPLACE (State or foreign country) <i>N.C.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Richardson</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USIA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Police Officer</i>
13a USIA. RESIDENCE (Where deceased lived at institution. Residence before) <i>Maryland</i>		13b CITY OR TOWN <i>Clarkburg</i>	13c INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13d STREET AND NUMBER <i>Route Box 98B</i>
14. FATHER'S NAME First Middle Last <i>Fitz Calvin</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Alice Lewis</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Sea Force</i>		16b SOCIAL SECURITY NO <i>Sea Force</i>	17 INFORMANT <i>Gene V. Fitz</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carbon Monoxide Poisoning</i> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i> <i>1/2 hr.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>9 P.M. 5/4 1969</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item B) <i>In garage</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home garage</i>	21f. LOCATION Street or RFD No City or Town County State <i>Route I Box 98 Clarkburg Montgomery Md</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John B. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>May 4, 1969</i>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>5/10/69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>John Wesley Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Clarkburg, Montg. Md.</i>	
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>	ADDRESS <i>Rockville, Md.</i>		25a. RECEIVED BY REGISTRAR <i>MAY 8 1969</i>	25b. REGISTRAR'S SIGNATURE <i>John B. Bell</i>

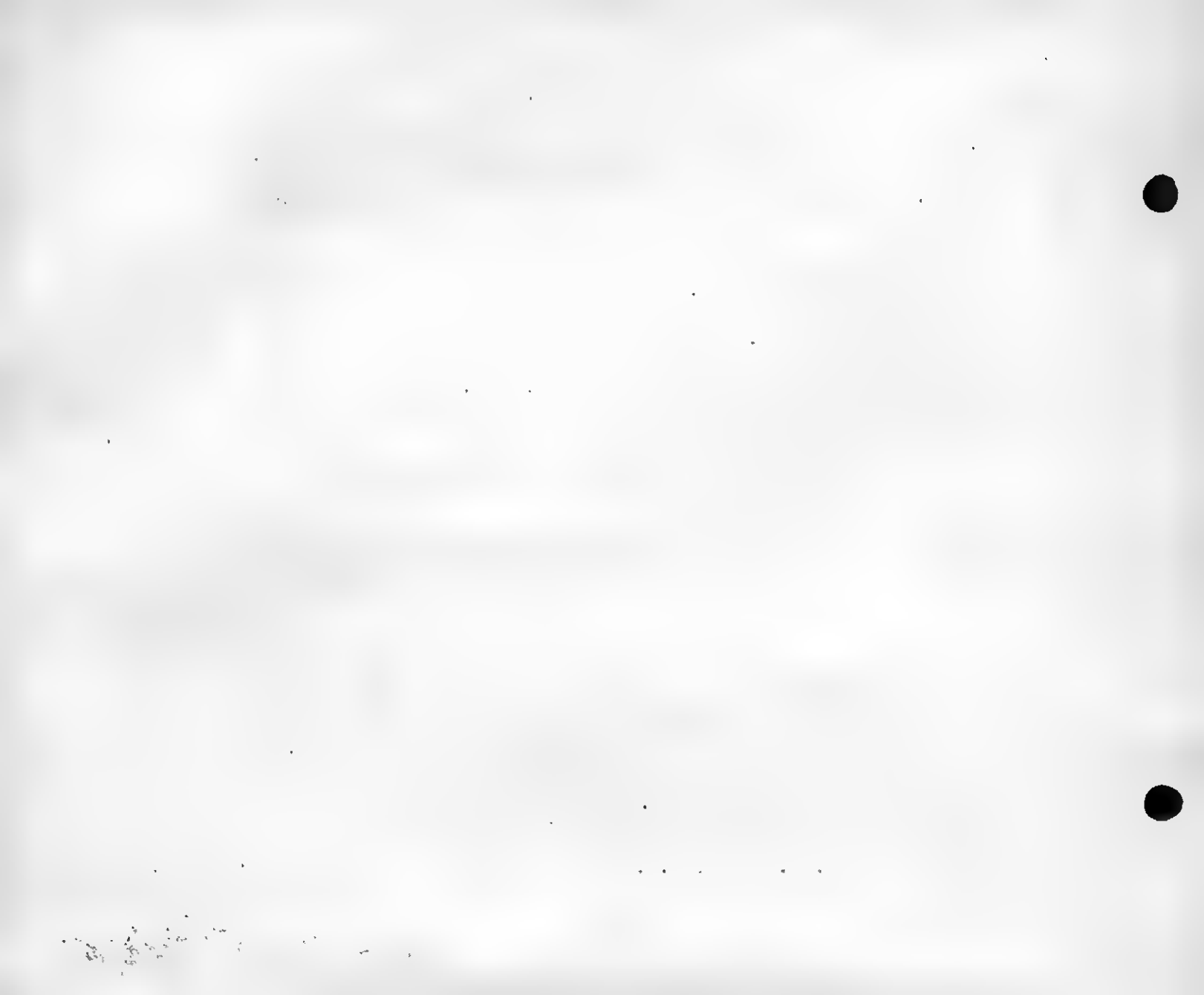
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
07073																	
07069																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Patricia			Middle Maureen			Last FLINN			2a. DATE OF DEATH May Month 20 Day 1969			2b. HOUR 920A M		
3 SEX Female			4. RACE Caucasian			5. DATE OF BIRTH August 29, 1957			6. AGE (In years last birthday) 11 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) N. Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			Md.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUA. OCCUPAT ON (Kind of work done during most of working life even if retired) N/A			12b. KIND OF BUSINESS OR INDUSTRY N/A								
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia			13b. COUNTY Pr. William			13c. CITY OR TOWN Woodbridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 20 Williamsburg Court					
14. FATHER'S NAME John			First D.			Middle Flinn			Last Jean			15. MOTHER'S MAIDEN NAME Turner			Va.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) N/A			16b. SOCIAL SECURITY NO N/A			17. INFORMANT John D. Flinn, 20 Williamsburg Court, Woodbridge			Address Va.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1943 Brain edema												1 week					
DUE TO, OR AS A CONSEQUENCE OF (b) Malignant pituitary chromophobe adenoma												2 years					
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (X) (this hospital) attended the deceased from May 8, 1969, to May 20, 1969, that (X) (we) last saw the deceased alive on May 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE C. B. Early			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED May 21, 1969								
22d. PHYSICIAN'S NAME (Type) C. B. EARLY, M.D.			22e. ADDRESS Naval Hospital, Bethesda, Md.														
23a. BURIAL CREMATION, ETC. Burial			23b. DATE 23 May 69			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.								
24. FUNERAL DIRECTOR Cunningham-Mountcastle			24b. ADDRESS Funeral Home, Woodbridge, Virginia			25a. REC'D BY REGISTRAR MAY 23 1969			25b. REGISTRAR'S SIGNATURE Charles Judge								

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1.68

<div style="display: flex; justify-content: space-between;"> 07074 MARYLAND STATE DEPARTMENT OF HEALTH 07070 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1 DECEASED-NAME (Type or Print) <i>ROGER P. Flynn Jr.</i>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>May</i> Day <i>11</i> Year <i>1969</i>			2b. HOUR <i>11:15</i> M <i>PM</i>		
3 SEX <i>M</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>12/21/1919</i>	6 AGE (in years last birthday) <i>19</i> YRS	7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	7 UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>May</i> Day <i>11</i> Year <i>1969</i>			2d. HOUR <i>11:15</i> M <i>PM</i>		
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Student</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Cherry Hill</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>ROGER</i> Middle <i>G.</i> Last <i>Flynn</i>			15. MOTHER'S MAIDEN NAME First <i>Edith</i> Middle <i>M.</i> Last <i>Cecil</i>			13e. STREET AND NUMBER <i>15 E. Melrose St.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes No, if unknown) <i>No</i>			16b. SOCIAL SECURITY NO			17 INFORMANT ADDRESS <i>Father - Roger Flynn Jr.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Congestion -</i>										<i>1/2 hr.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>ast</i>										(b) <i>Destruction of Frontal Lobes of Brain</i>	
										(c) <i>Trauma from Auto Accident.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>July 12 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>During car involved in accident.</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Street</i>		21f. LOCATION Street or R.F.D. No <i>River Rd Burdette</i>		City or Town <i>Bethesda</i>		County <i>Montgomery</i>		State <i>Md</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>May 12, 1969</i>			
EXAMINER'S NAME (Type) <i>John G Ball</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county) <i>Bethesda, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 14, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Gabriels</i>		23d. LOCATION (City or Town) <i>Potomac</i>		(County) <i>Montgomery</i>		(State) <i>Md</i>	
24 FUNERAL DIRECTOR <i>Robert A. Humphrey</i>				7557 Wisconsin Ave Bethesda, Md				25a. REC'D BY REGISTRAR <i>MAY 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First THOMAS			Middle HENRY C.			Last FLYNN		
2a. DATE OF DEATH			Month 5 Day 2 Year 69			2b. HOUR 9:10A			M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5-24-83			6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER			12b. KIND OF BUSINESS OR INDUSTRY FARMING			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN DAMASCUS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 24929 RIDGE ROAD			
14. FATHER'S NAME			First ZACKERY T.			Middle FLYNN			Last		
15. MOTHER'S MAIDEN NAME			First ROSA			Middle LEE			Last SMITH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 213-56-1895		17. INFORMANT MEDICAL RECORD DEPT.				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Arteriosclerotic Cardiovascular Disease										Years	
DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No accident							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from April 17, 1969 , to May 2, 1969 , that (I) (we) last saw the deceased alive on May 2, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dia) (diagnose) view the body after death.											
22b. SIGNATURE <i>M. McKendree Boyer</i>						22c. DATE SIGNED May 2, 1969		22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.			
22e. ADDRESS 9701 CHURCH ST., DAMASCUS, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Upper Seneca Baptist			23d. LOCATION (City or Town)		(County)		(State)
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.						25a. REC'D BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>			

MEDICAL CERTIFICATE ON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			Month	Day	Year	2b. HOUR	
MAY				L.	FRIEDMAN	MAY			1		1969	4:15 A	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		
male		white		10-20-00			68 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Poland		U.S.A.					Montgomery Md						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring				Holy Cross				Upholstering				Upholstering	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER			
D.C.				13b. COUNTY		Washington				1416 Ogelthorpe St. N.W.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Louis					Friedman	Gitel					?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT			Address				
No						WIFE			MRS. REBECCA FRIEDMAN - AS ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4109</u> <u>ACUTE MYOCARDIAL INFARCTION</u>												1 hour	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>	
DUE TO, OR AS A CONSEQUENCE OF												(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>68</u> , to <u>APRIL</u> , 19 <u>69</u> ; that (I) (we) last saw the deceased alive on <u>30 APRIL</u> , 19 <u>69</u> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Ira N. Tublin</u>				22d. PHYSICIAN'S NAME (Type) <u>IRA N. TUBLIN</u>		22e. ADDRESS <u>MD 800-PERSHING DR. SIL-SPG. MD</u>		22c. DATE SIGNED <u>5/1/69</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE <u>5-2-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELESABETTERAD CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON DC</u>					
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY</u>				ADDRESS <u>WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAY 6 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 455 (4)
45M 1/69

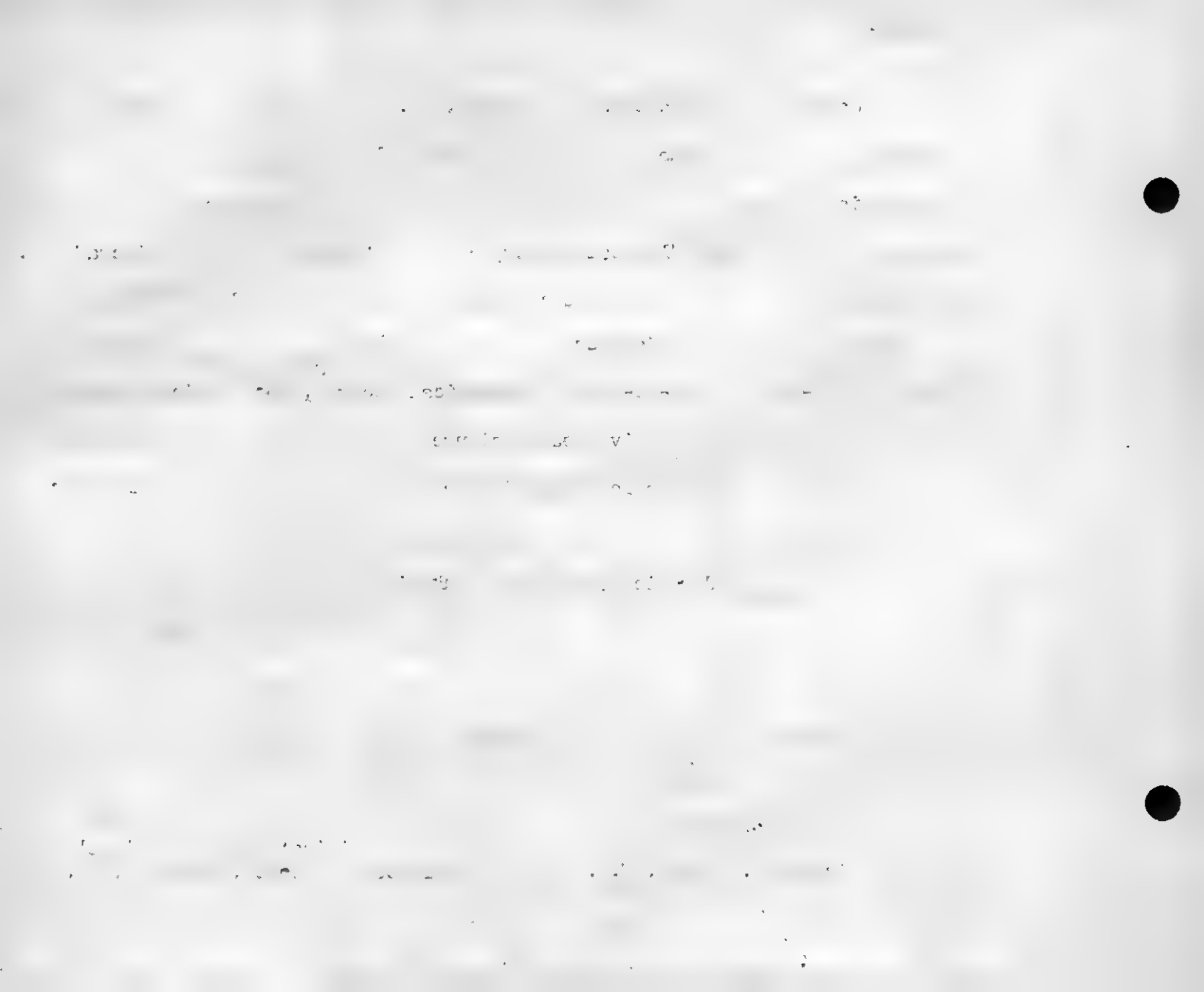
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>Anna May Gamage</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>19</i> Year <i>1969</i>			2b. HOUR <i>4:25 PM</i>			
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>7/14/1920</i>		6. AGE (In years last birthday) <i>48 1/4</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Suburban Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4501-Parfield Dr.</i>	
14. FATHER'S NAME First Middle Last <i>Irvin Todd</i>		15. MOTHER'S M.A.D.E.N. NAME First Middle Last <i>Lane Jackson</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO <i>579-12-0698</i>		17. INFORMANT <i>John Williams</i> Garage Address <i>11908 Reynolds Ave., Rockville</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma rophagus et metastasis</i>									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>8-3</i> , 19 <i>69</i> , to <i>5-19</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-14</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>V.C. deGuzman</i>		22c. DATE SIGNED <i>5-20-69</i>		22d. PHYSICIAN'S NAME (Type) <i>VICENTE C. DE GUZMAN</i>					
22e. ADDRESS <i>1234 19th St NW WASH D.C.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/22/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Maryland</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		24b. ADDRESS <i>Rockville, Md.</i>		24c. DATE <i>MAY 22 1969</i>		24d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

07078		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07074	
1. DECEASED NAME (Type or print)			2a. DATE OF DEATH			2b. HOUR	
James Lawrence Gardner, Sr.			May 8 1969			1:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		White		6 March 1919		50 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Pennsylvania		USA				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		The Clinical Center, NIH		Laborer		Aircraft Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Pennsylvania		Clinton		Beech Creek		Locust Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
Raymond Gardner			Lula Council				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		
Yes 1943-1945			159-12-5035		Bethesda, Maryland 20014 The Medical Records, The Clinical Center,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>20 Years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Myelogenous Leukemia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7 May</u> , 19 <u>69</u> , to <u>8 May</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8 May</u> , 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.							
22b. SIGNATURE <u>Michael B. Mosher</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8 May 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Michael B. Mosher, M.D.</u>				22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5-11-69		Highland Cemetery		Liberty Twp, Centre, Pa.	
24. FUNERAL DIRECTOR <u>Bruce G. Beechler, Beech Creek, Pa.</u>				25a. REC'D BY REGISTRAR <u>MAY 13 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07079		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07075					
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Annie Estelle GERMANN						Month May	Day 31	Year 1969	M		
3 SEX Female		4. RACE White		5. DATE OF BIRTH December 19, 1894		6 AGE (in years last birthday) 74 YRS.		FINDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Annapolis, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Same					
13a. USJA. RESIDENCE (Where deceased lived, if admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Baltimore		13d. INS-DE CITY JUN 15? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2408-Dennis Avenue			
14. FATHER'S NAME Robert Fairall		First	Middle	Last	15. MOTHER'S MA DEN NAME Matilda Scaggs		First	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO 217-14-7125		17. INFORMANT Ernest Germann Ahane		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2507 acute coronary occlusion few min. DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus & obesity years PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Rheumatoid arthritis - crippling, Parkinson's disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb 76, 1969, to May 1, 1969, that (I) (we) last saw the deceased alive on 4-29-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d) not view the body after death.											
22b. SIGNATURE John R. Spencer M.D.		22c. DATE SIGNED 5-1-69		22d. PHYSICIAN'S NAME (Type)							
23a. BURIAL CREMATION REMOVED (Specify)		23b. DATE 5-5-69		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md					
24. FUNERAL DIRECTOR Donaldson Funeral Home		ADDRESS Baltimore		25a. REC'D BY REG. STRAR DATE May 6, 1969		25b. REG. STRAR'S SIGNATURE James J. J.					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07080

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07076

1 DECEASED NAME (Type or Print) <i>Bradley</i> First Middle Last <i>Monroe Gerwig</i>		2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <i>1969</i>		2b HOUR <i>3:10 PM</i>
3 SEX <i>MALE</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>7/20/17</i>	6 AGE in years (lost birthday) <i>51</i> YRS	7c DATE PRONOUNCED DEAD Month <i>5</i> Day <i>7</i> Year <i>1969</i>
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10 CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DOA Suburban Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Guard</i>
13a USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) STATE <i>MD.</i>		13b COUNTY <i>Fredrick</i>		13c CITY OR TOWN <i>Fredrick</i>
14 FATHER'S NAME First <i>Harry</i> Middle <i>T.</i> Last <i>Gerwig</i>		15 MOTHER'S MAIDEN NAME First <i>Daisy</i> Middle <i>Bazzell</i> Last <i>Bazzell</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16b SOCIAL SECURITY NO. <i>W.W. 2 216-16-5695</i>		17. INFORMANT ADDRESS <i>Mrs. Ruby Gerwig Frederick, Maryland</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion.</i> <i>4107</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Arterio Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i> <i>Years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i>P.M.</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>May 8, 1969</i>
EXAMINER'S NAME (Type) <i>John G. Ball</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>Montgomery County</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>5-10-1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>
23d LOCATION (City or Town) <i>Frederick, Maryland</i>		23e LOCATION (County) <i>Frederick, Md.</i>		23f LOCATION (State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Robert E. Dailey & Son</i>		ADDRESS <i>Frederick, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 16 1969</i>
25b. REGISTRAR'S SIGNATURE <i>Robert E. Dailey</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07081		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07077	
1. DECEASED-NAME (Type or print) <i>William T. Gibb</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>10</i> Year <i>1969</i>			2b. HOUR <i>11:30</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>5-9-1902</i>		6. AGE (In years last birthday) <i>67</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>New York City</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Physician</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>	
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kennett</i>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>2700 West Bechtel Dr</i>		14. FATHER'S NAME First <i>William</i> Middle <i>T</i> Last <i>Gibb</i>		15. MOTHER'S MAIDEN NAME First <i>Alice</i> Middle <i>Stearns</i> Last <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>220-44-6206</i>		17. INFORMANT <i>Dr. S. Peter Gibb - son</i>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i> <i>6 mo.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Status post gastrectomy for Carcinoma of Stomach</i>							
19a. DATE OF OPERATION <i>Dec 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11 May 1968</i> to <i>11 May 1969</i> , that (I) (we) last saw the deceased alive on <i>11 May 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>John H. H. H. H. H.</i>		22c. DATE SIGNED <i>12 May 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>John H. H. H. H. H.</i>			
22e. ADDRESS <i>4477 R. H. H. H.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5/13/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON, D.C.</i>	
24. FUNERAL DIRECTOR <i>Martin W. H. H. H.</i>		25a. REC'D BY REGISTRAR <i>MAY 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i></i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Karban papers (Pages 1 and 2) and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07082

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07078

1 DECEASED-NAME (Type or print) <u>Loel</u> First <u>Mini</u> Middle <u>Gilbert</u> Last			2a. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>69</u>			2b. HOUR <u>2:55</u> PM	
3 SEX <u>Female</u>		4. RACE <u>White</u>		5 DATE OF BIRTH <u>12-3-36</u>		6 AGE (In years last birthday) <u>32</u> YRS	
7a BIRTHPLACE (State or foreign country) <u>La.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12b KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md.</u>		13b COUNTY <u>montgomery</u>		13c CITY OR TOWN <u>CHERRY CHASE</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <u>L.</u> Middle <u>RICHARD</u> Last <u>HASPEL</u>		15 MOTHER'S MAIDEN NAME First <u>HERMINA</u> Middle <u>—</u> Last <u>MOOG</u>		13e STREET AND NUMBER <u>3218 THORNAPPLE ST.</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>		(If yes give war or dates of service) <u>—</u>		16b SOCIAL SECURITY NO <u>—</u>		17 INFORMANT <u>PAUL R. GILBERT - SAME AS #13</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Adenocarcinoma of Breast</u> (b) <u>29YRS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few months</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
9a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <u>69</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>69</u> , to <u>5/14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>G. Leonard Gold</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>5/14/69</u>	
22d PHYSICIAN'S NAME (Type) <u>G. LEONARD GOLD</u>				22e ADDRESS <u>9801 GERRIT AVE, SL, SPR, MD.</u>			
23a BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL TRANSIT</u>		23b DATE <u>5/16/69</u>		23c NAME OF CEMETERY OR CREMATORY <u>GARDEN OF MEMORIES</u>		23d LOCATION (City or Town) (County) (State) <u>JEFFERSON PARISH, LOUISIANA</u>	
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SONS, 5130 WISCONSIN AVE.-N.W., WASHINGTON, D.C.</u>				25a REC'D BY REGISTRAR DATE <u>MAY 20 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

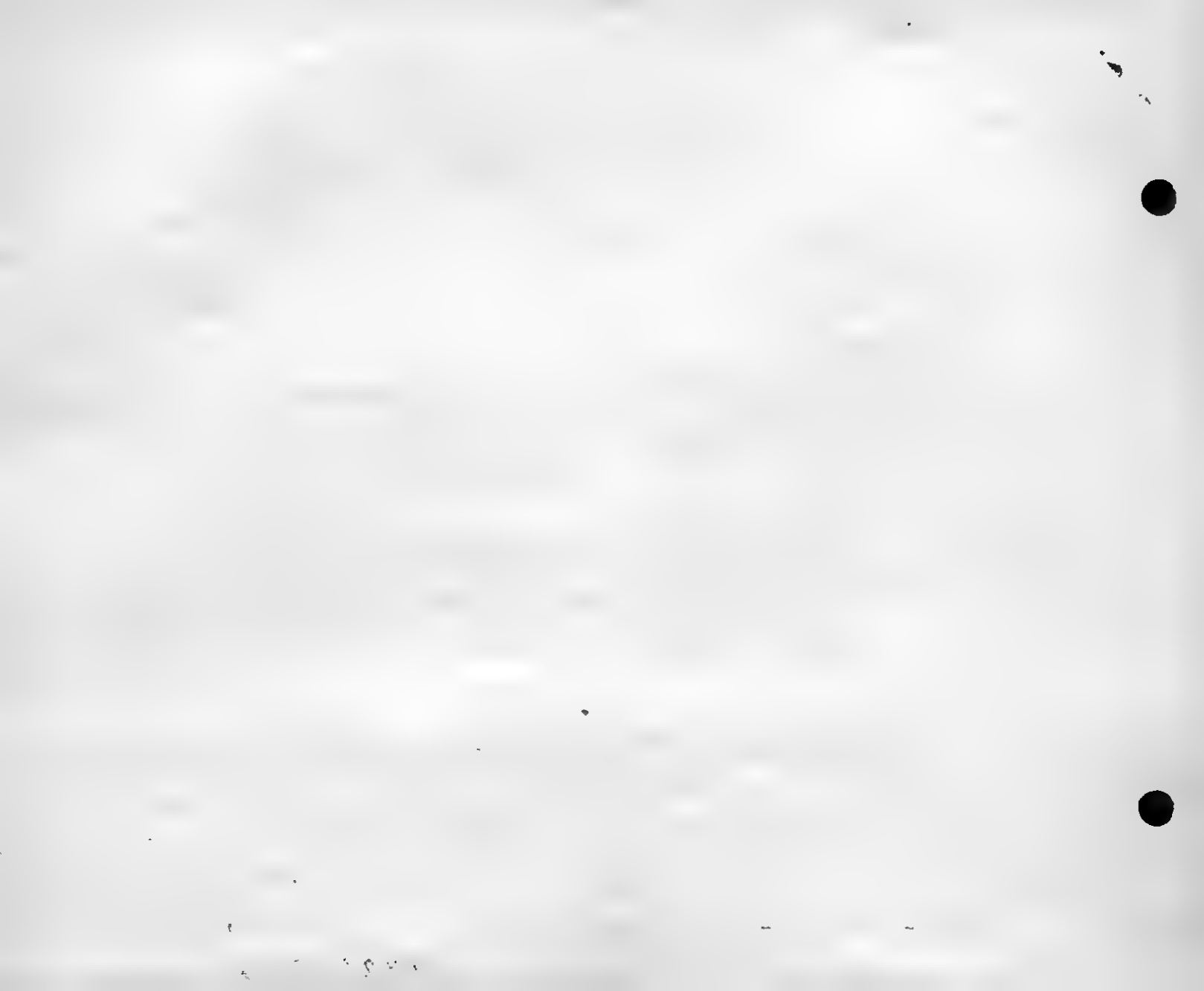
07083

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07079

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Leif</i>		Middle <i>Elstad</i>		Last <i>Elstad</i>		2a. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1969</i>			2b HOUR- <i>1:05</i> PM		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>10/20/1915</i>		6 AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			Md		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>TRANSPORTATION</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>M.D.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5300 Western Ave. Beth.</i>			
14 FATHER'S NAME <i>Lewis</i>		Middle <i>Elstad</i>		Last <i>Elstad</i>		15. MOTHER'S MAIDEN NAME <i>Dina Houelshrud</i>			Last		
16a. WAS DECEASED IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>492-01-7923</i>		17 INFORMANT <i>Wife, Josephine M. Elstad</i>		Address					
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Adenocarcinoma colon with metastasis</i> <i>1538</i> DUE TO, OR AS A CONSEQUENCE OF <i>To Smaller Intestine, Liver, Adrenal & lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Coronary Arteriosclerosis and emphysema</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>January 19</i> to <i>17 May</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>May 6</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>A. Richwine</i>		22c. PHYSICIAN'S NAME (Type) <i>A. RICHWINE</i>		22d. ADDRESS <i>5322 WESTERN AVE CHEVY CHASE, Md.</i>		22e. DATE SIGNED <i>May 19 1969</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>5-20-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lakewood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Minneapolis, Minnesota</i>					
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, INC.</i>				25a. REC'D BY REGISTRAR <i>MAY 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First <i>Sadie</i>		Middle		Last <i>Gittings</i>		2a DATE OF DEATH Month <i>5</i> Day <i>23</i> Year <i>69</i>		2b HOUR <i>5 AM</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>8-4-82</i>		6 AGE (In years last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>				Md.	
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>own home</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Wheaton 'Nuts' Home</i>			
14 FATHER'S NAME First <i>John E. Graham</i>		Middle		Last		15 MOTHER'S M.A.DEN NAME First <i>Alice Leizear</i>		Middle		Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b SOCIAL SECURITY NO. <i>No</i>		17 INFORMANT <i>Mrs. Betty Mandley</i>		12304 <i>Ch. Ave.</i>		<i>Silver Spring, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>myocardial infarction</i>										<i>2 days</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic vascular disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1967</i> to <i>MAY 23 1969</i> , that (I) (we) last saw the deceased alive on <i>23 MAY 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b SIGNATURE <i>Walter E. Goetz</i>		22c. PHYSICIAN'S NAME (Type) <i>Walter E. Goetz</i>		22d. ADDRESS <i>2309 Shorefield Rd., Wheaton, Md.</i>		22e. DATE SIGNED <i>5/24/69</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b DATE <i>May 26, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>		23d LOCATION (City or Town) <i>Bladensburg, Md.</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>Smith, Russell</i>		ADDRESS <i>8434 Gd. Ave.</i>		25a. REC'D BY REGISTRAR <i>Walter E. Pumphrey</i>		DATE <i>MAY 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07085

CERTIFICATE OF DEATH

07081

1 DECEASED-NAME (Type or print) <u>Le Roy</u>			First Middle Last			2a. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>69</u>			2b. HOUR <u>11:35</u> A.M.		
3 SEX <u>male</u>			4. RACE <u>white</u>			5 DATE OF BIRTH <u>10/1/88</u>			6 AGE (in years lost birthday) <u>80</u> YRS.		
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Montgomery</u> Md		
10 CITY OR TOWN OF DEATH <u>Rockville</u>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Potomac Valley Hosp. Home</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>md.</u>			13b. COUNTY <u>Mont.</u>			13c. CITY OR TOWN <u>Gaithersburg</u>			13d. INS OR CITY-INS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <u>Robert</u> Middle <u>Glenn</u> Last <u>Hurd</u>			15 MOTHER'S M A D E N NAME First <u>Margaret</u> Middle <u>Hurd</u> Last <u>Hurd</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO <u>718-14-9561</u>		
17 INFORMANT <u>Leroy Glenn Hurd</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma left lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>12 yrs</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 1968, to <u>5-24</u> , 1969, that (I) (was) last saw the deceased alive on <u>5-24</u> , 1969, and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death											
22b. SIGNATURE <u>W. G. Hall</u>			22c. DATE SIGNED <u>5/24/69</u>			22d. PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>5-27-69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>			23d. LOCATION (City or Town) (County) (State) <u>Falls Church Va</u>		
24. FUNERAL DIRECTOR <u>Ernest C. Gortner</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			25c. DATE <u>MAY 28 1969</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07086

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07082

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <i>Adam J Goepfert Sr.</i>			2a DATE OF DEATH Month Day Year <i>May 30 1969</i>			2b HOUR <i>2:35 PM</i>				
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>1/23/91</i>		6 AGE (in years last birthday) <i>78</i> YRS.		F UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			Md	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Hospital</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <i>Maryland</i>			13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Art 102 11925 Parklawn Dr.</i>	
14 FATHER'S NAME First Middle Last <i>John Goepfert</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Mary Phillips</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO <i>111-12-6592</i>	
17 INFORMANT <i>ANNA GOEPFERT</i> Address <i>11925 PARKLAWN DR, ROCKVILLE, MD.</i>			18			19			20	
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>coronary atherosclerosis</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sev. hours</i> <i>many years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes mellitus</i>										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC			21f LOCATION Street or RFD No		City or Town		State
22a. I certify that (I) (the hospital) attended the deceased from <i>May 29</i> , 19 <i>63</i> , to <i>May 30</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>May 29</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b SIGNATURE <i>George H. Mitchell</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>5/30/69</i>		
22d PHYSICIAN'S NAME (Type) <i>George H. Mitchell</i>			22e ADDRESS							
23a BURIAL PLACES OR REMOVAL (Specify)			23b DATE <i>6-3-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Rockville Md.</i>			
24 FUNERAL DIRECTOR <i>Robert A. Humphrey</i>						ADDRESS <i>7557 rick</i>		25a REC'D BY REGISTRAR DATE <i>June 5, 1969</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07087										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07083																													
1 DECEASED-NAME (Type or print)										2a DATE OF DEATH										2b HOUR																													
First Middle Last Joseph William GORMAN										Month Day Year May 9 1969										1:00aM																													
3 SEX Male										4 RACE Caucasian										5. DATE OF BIRTH 9 November 1910										6. AGE (In years last birthday) 58 YRS.										7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
7a BIRTHPLACE (State or foreign country) Penna.										7b CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md.																			
10 CITY OR TOWN OF DEATH Bethesda, Maryland										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired										12b KIND OF BUSINESS OR INDUSTRY																			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE FLORIDA										13b CITY OR TOWN Escambia										13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 1509 N.R ST.																			
14 FATHER'S NAME First Middle Last										15 MOTHER'S MAIDEN NAME First Middle Last																																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war and dates of service)										16b SOCIAL SECURITY NO.										17 INFORMANT Sister-in-law Mrs. Ruby Barney Address Same as Item 13.																													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Recurrent carcinoma, base of tongue 1410 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (a) (this hospital) attended the deceased from 11 Feb., 1969, to 9 May, 1969, that (b) (we) lost saw the deceased alive on 9 May, 1969, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (do not) view the body after death.										22b. SIGNATURE Robert P. Majors Jr. MD										22c. DATE SIGNED 10 MAY 1969																													
22d. PHYSICIAN'S NAME (Type) Robert P. Majors, MD										22e. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 5-13-69										23c. NAME OF CEMETERY OR CREMATORY Barrancas Natl Cem.										23d. LOCATION (City or Town) (County) (State) Pensacola, Florida																			
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland										25a. REC'D BY REGISTRAR MAY 15 1969										25b. REGISTRAR'S SIGNATURE																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07088											
CERTIFICATE OF DEATH											
07084											
1 DECEASED NAME (Type or print)			First LOUIS			Middle JOHN			Last GOUCHER		
2a. DATE OF DEATH			May			Month			28 Day		
2b. HOUR			7:25 P.M.								
3. SEX			Male			4. RACE			Caucasian		
5. DATE OF BIRTH			April 22, 1897			6. AGE (In years last birthday)			72 YRS.		
7a. BIRTHPLACE (State or foreign country)			Massachusetts			7b. CITIZEN OF WHAT COUNTRY?			USA		
8. MARRIED			<input checked="" type="checkbox"/> NEVER MARRIED			9. COUNTY OF DEATH			Montgomery		
10. CITY OR TOWN OF DEATH			Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			Naval Hospital		
12a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			Maryland			12b. KIND OF BUSINESS OR INDUSTRY			Military		
13a. CITY OR TOWN			Annapolis			13b. STREET AND NUMBER			1206 Van Buren Drive		
14. FATHER'S NAME			Charles			15. MOTHER'S MAIDEN NAME			Honora		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			Yes			16b. SOCIAL SECURITY NO.			577-44-2173		
17. INFORMANT			Rose E. GOUCHER (Wife)			18. ADDRESS			1206 Van Buren Drive, Annapolis, Maryland		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
22a. I certify that (X) (this hospital) attended the deceased from May 20, 1969, to May 28, 1969, that (X) (we) last saw the deceased alive on May 28, 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22b. SIGNATURE			D. K. ROEDER, LCDR MC USN			22c. DATE SIGNED			29 May 1969		
22d. PHYSICIAN'S NAME (Type)			D. K. ROEDER, LCDR MC USN			22e. ADDRESS			Naval Hospital, Bethesda, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6-2-69			Arlington National Cemetery			Arlington Fairfax Va.		
24. FUNERAL DIRECTOR			W.W. CHAMBERS FUNERAL			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
HOME, 3072 M Street, N.W., Washington, D. C.						JUN 4 1969			Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16-2-69 07089 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07085

1. DECEASED-NAME (Type or Print) Thomas James Gowen Sr				2a. DATE KNOWN OF DEATH 5 8 69				2b. HOUR 6:49A	
3 SEX Male	4 RACE White	5. DATE OF BIRTH 3-16-19	6 AGE (In years lost birthday) 50 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN 	2c. DATE PRONOUNCED DEAD Month 5 Day 8 Year 1969		2d. HOUR 6:49A	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? Amer U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Takoma Pk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY VEHICLE FACTORY	
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Maryland COUNTY PRINCE GEORGES		13b. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1927 Red Oak Dr			
14. FATHER'S NAME First Joseph Middle Patrick Last Gowen				15. MOTHER'S MAIDEN NAME First GRACE Middle Burch Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220 05 9396		17. INFORMANT MRS. DORIS M. GOWEN				ADDRESS SAME AS #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary insufficiency 412.0 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State 	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Peap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED MAY 8, 1969	
EXAMINER'S NAME (Type) BELDEN R. PEAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE MAY 10, 1969		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM	
23d. LOCATION (City or Town) COLMAR MANOR, MARYLAND		23e. LOCATION (City or Town) (County) (State) 		23f. LOCATION (City or Town) (County) (State) 	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD		25a. REC'D BY REGISTRAR MAY 14, 1969		25b. REGISTRAR'S SIGNATURE 	

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR	
Joyce		H.	GRANGER		May		3	69	215P M	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	Caucasian		August 20, 1898		70 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
W. Virginia		USA				Montgomery		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda, Md.		Naval Hospital		Housewife		N/A				
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, IN 157		13e. STREET AND NUMBER		
Virginia		Fairfax		Alexandria		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6405 16th Street		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address
Theodore George		Eliza Verde		FRUM		Mrs. Stanley F. Rollin, 1905 Oren Dr. Laurel		Maryland		
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>69</u> , to <u>May 3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Douglas L. Horton, M.D.</u>		22c. DATE SIGNED May 5, 1969		22d. PHYSICIAN'S NAME (Type) Douglas L. Horton, M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-7-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington Va.				
24. FUNERAL DIRECTOR Everly-Wheatley		25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

07091

07087

1 DECEASED NAME (Type or Print) Eugene Alston Green Jr.			2a DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1969 2b HOUR 3:30 PM		
3 SEX M.	4 RACE W.	5 DATE OF BIRTH April 1, 1947	6 AGE (In years last birthday) 22 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery		9d DATE PRONOUNCED DEAD Month May Day 8 Year 1969 2d HOUR 5:45 PM			
10 CITY OR TOWN OF DEATH Near Cabin John		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac River		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STUDENT	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Va.		13b COUNTY Alexandria		13c CITY OR TOWN Alexandria	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6410 South Lan Dorn St.			
14 FATHER'S NAME First Eugene Middle ALSTON Last GREEN			15. MOTHER'S MAIDEN NAME First MERLE Middle BRASWELL Last BRASWELL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO. 228-66-1398		17 INFORMANT ADDRESS MOTHER SAME AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning - 7100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) While swimming in Potomac River DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN -
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 3:30 PM 5-4 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Swimming in River suddenly sank	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Potomac River		21f LOCATION Street or RFD No City or Town County State Sandy Landing, Widewater, Great Falls Fairfax Va.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED May 8, 1969	
EXAMINER'S NAME (Type) JOHN G. BALL		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE MAY 12, 1969		23c NAME OF CEMETERY OR CREMATORY POWICK CEMETERY	
		23d LOCATION (City or Town) (County) (State) POWICK FAIRFAX Va.			
24 FUNERAL DIRECTOR TYSON WHEELER FH. ROCKVILLE		25a. REC'D BY REGISTRAR MARYLAND, MAY 12 1969		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form 10-100, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07092		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07088	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
Edward Bryan Grimes						5-4-69	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)	
Male		White		10-11-96		72 YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Maryland		U.S.				Montgomery Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.J.A. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Belpre Health Center		Carpenter		building	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d HOUSE CITY LIMITS?	
Md.		Howard		West Friendship Md		NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		17 INFORMANT	
Bazzell		Grimes		Mary		1801 Bonifant Rd, Silver Springs, Md.	
						20906	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Pulmonary Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchial Neoplasm</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-20-1969, to 5-4-1969, that (we) (we) saw the deceased alive on 5-4-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rafael C. Inclan				22c. DATE SIGNED May 4, 1969			
22d. PHYSICIAN'S NAME (Type) RAFAEL C. INCLAN				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/7/69		Higinbotham		Ellicott City, Md.	
24. FUNERAL DIRECTOR Higinbotham Slack				25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Charles J. Judd	



07093

CERTIFICATE OF DEATH

07089

1. DECEASED NAME (Type or print) Bessie Gertrude Gurn			2a. DATE OF DEATH Month May Day 17 Year 1969		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 27, 1881		6. AGE (In years last birthday) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign) Chicago, Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Oak Haven Nursing Home		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Musical Teacher	12b. KIND OF BUSINESS OR INDUSTRY Teaching	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. IN DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7906 Takoma Avenue	
14. FATHER'S NAME First Middle Last Samuel O. Bracken			15. MOTHER'S MAIDEN NAME First Middle Last Bertha Delange		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 336-01-6377	17. Lewisdale, Md. Address 2303 Drexel Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1952 to May 17, 1969 , that (I) (we) last saw the deceased alive on May 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Frank S. Bacon			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED May 17, 1969	
22d. PHYSICIAN'S NAME (Type) Frank S. Bacon			22e. ADDRESS 2141-K- Street NW Washington, DC		
23a. BURIAL, CREMATION, or MOVAT (Specify) Burial	23b. DATE May 20, 1969	23c. NAME OF CEMETERY OR CREMATORY Forest Home	23d. LOCATION (City or Town) (County) (State) Forest Park, Illinois		
24. FUNERAL DIRECTOR Warner O. Pumphrey, Inc. 8434 Ga. Ave. Sil Spg.			25a. REC'D BY REGISTRAR MAY 20 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07094

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07090

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year			2b HOUR
Buth H. Haberman						May 2 1969			5:47 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	12/15/04	64 YRS					May 2 1969	5:47 PM
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Washington D.C.		U.S.A.				Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington San. + Hosp.			Resident manager			Apt. House
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER
Maryland			Prince George Hyattsville			YES			3213 University Blvd. Apt 104 E
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John						Blanche			Elberly
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS
No			578 09 1212			H.S.H. Hospital Records			Takoma Park Md
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Artery Heart Disease.</u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF <u></u> (c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
Belden R. Read M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			May 2, 1969			
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			5/6/69		Glenwood		Washington D.C.		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REG STRAR		
Francis Gasch's Sons Hyattsville, Md.							MAY 7 1969		
							25b. REG STRAR'S SIGNATURE		
							Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07095		CERTIFICATE OF DEATH						07091	
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
Frances B. Hackett								Month Day Year	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR	
Female		White		5-24-1896		65 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
New Jersey		U. S.				Montgomery		Wheaton	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY, TOWNSHIP		13b. STREET AND NUMBER	
Nursing Home		housewife		none		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8000 Old Georgetown Rd.	
13c. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13d. COUNTY		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Md		Montgomery		John Burleigh		Anna Heintz		Yes, no or unknown	
16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION	
579-42-9342-A		Mrs. Ed and Schapfer		1. IMMEDIATE CAUSE (a) CARCINOMA OF THE BREAST		35 yrs		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
				2. DUE TO, OR AS A CONSEQUENCE OF				20a. AUTOPSY?	
				3. DUE TO, OR AS A CONSEQUENCE OF				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				4. DUE TO, OR AS A CONSEQUENCE OF				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				5. DUE TO, OR AS A CONSEQUENCE OF					
				6. DUE TO, OR AS A CONSEQUENCE OF					
				7. DUE TO, OR AS A CONSEQUENCE OF					
				8. DUE TO, OR AS A CONSEQUENCE OF					
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				24. DUE TO, OR AS A CONSEQUENCE OF					
				25. DUE TO, OR AS A CONSEQUENCE OF					
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				99. DUE TO, OR AS A CONSEQUENCE OF					
				100. DUE TO, OR AS A CONSEQUENCE OF					

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<div style="display: flex; justify-content: space-between;"> 07092 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07092 </div> <div style="display: flex; justify-content: space-between;"> Item 5 Film 413 5/29/69 kk CERTIFICATE OF DEATH </div>												
1. DECEASED NAME (Type or print) First Middle Last <i>Emma Lettie Hackney</i>						2a. DATE OF DEATH Month Day Year <i>May 20 1969</i>			2b. HOUR <i>11:30</i> AM			
3. SEX <i>Female</i>		4. RACE <i>Cal</i>		5. DATE OF BIRTH <i>3/15/1913</i>		6. AGE (In years last birthday) <i>56</i> YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>domestic</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before adm ssion) STATE <i>Md</i>				13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY L.M. 15? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>316 Lincoln Ave</i>		
14. FATHER'S NAME First Middle Last <i>Richard Leroy</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Lillie Pratt</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO <i>1</i>		17. INFORMANT <i>Husband Joseph Hackney</i>			Address <i>same as above</i>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Shock probably due to bacteremia</i> DUE TO, OR AS A CONSEQUENCE OF <i>Brain damage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Hemorrhage from aneurysm circle of Willis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 1/2 months</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>												
19a. DATE OF OPERATION <i>Feb. 20 69</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>aneurysm circle of Willis</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 2</i> , 1969, to <i>May 20, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 19</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (aid) not view the body after death												
22b. SIGNATURE <i>A. Bonville Hunter, Jr. MD</i>						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>May 20, 1969</i>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>5/23/69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>LINCOLN PARK</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg, Md.</i>			
24. FUNERAL DIRECTOR <i>James A. Snowden Rockville</i>						ADDRESS			25a. REC'D BY REGISTRAR <i>MAY 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James A. Snowden</i>	

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VR A 11 69
45M

07097

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07093

1 DECEASED NAME (Type or print) Thomas Wesley HARTLEY			2a. DATE OF DEATH Month May Day 25 Year 69			2b. HOUR 11:48 M	
3 SEX Male		4 RACE CAUC		5 DATE OF BIRTH 10/29/42		6 AGE (In years last birthday) 7.5 YRS.	
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md	
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP.		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) CAB DRIVER		12b. KIND OF BUSINESS OR INDUSTRY TAXI	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 256 PARK AVE.		14 FATHER'S NAME First JOHN Middle HARTLEY Last HARTLEY		15 MOTHER'S MAIDEN NAME First SUSAN Middle 3 Last HARRIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 571-48-3750		17 INFORMANT HOSPITAL RECORD		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GI Bleeding 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PROBABLE MESENTERIC INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE PANCREATIC CANCER							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 HOURS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAY 18 , 19 69 , to MAY 25 , 19 69 , that (I) (we) last saw the deceased alive on MAY 25 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gene U. Cohen MD DEGREE				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-25-1969	
22d. PHYSICIAN'S NAME (Type) GENE U. COHEN				22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 5-29-69		23c. NAME OF CEMETERY OR CREMATORY WASH. NAT. CEM		23d. LOCATION (City or Town) (County) (State) SUITLAND MD	
24 FUNERAL DIRECTOR W.W. Chambers Co		ADDRESS 1400 Chapin ST. N.W.		25a. REC'D. BY REGISTRAR MAY 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMC-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

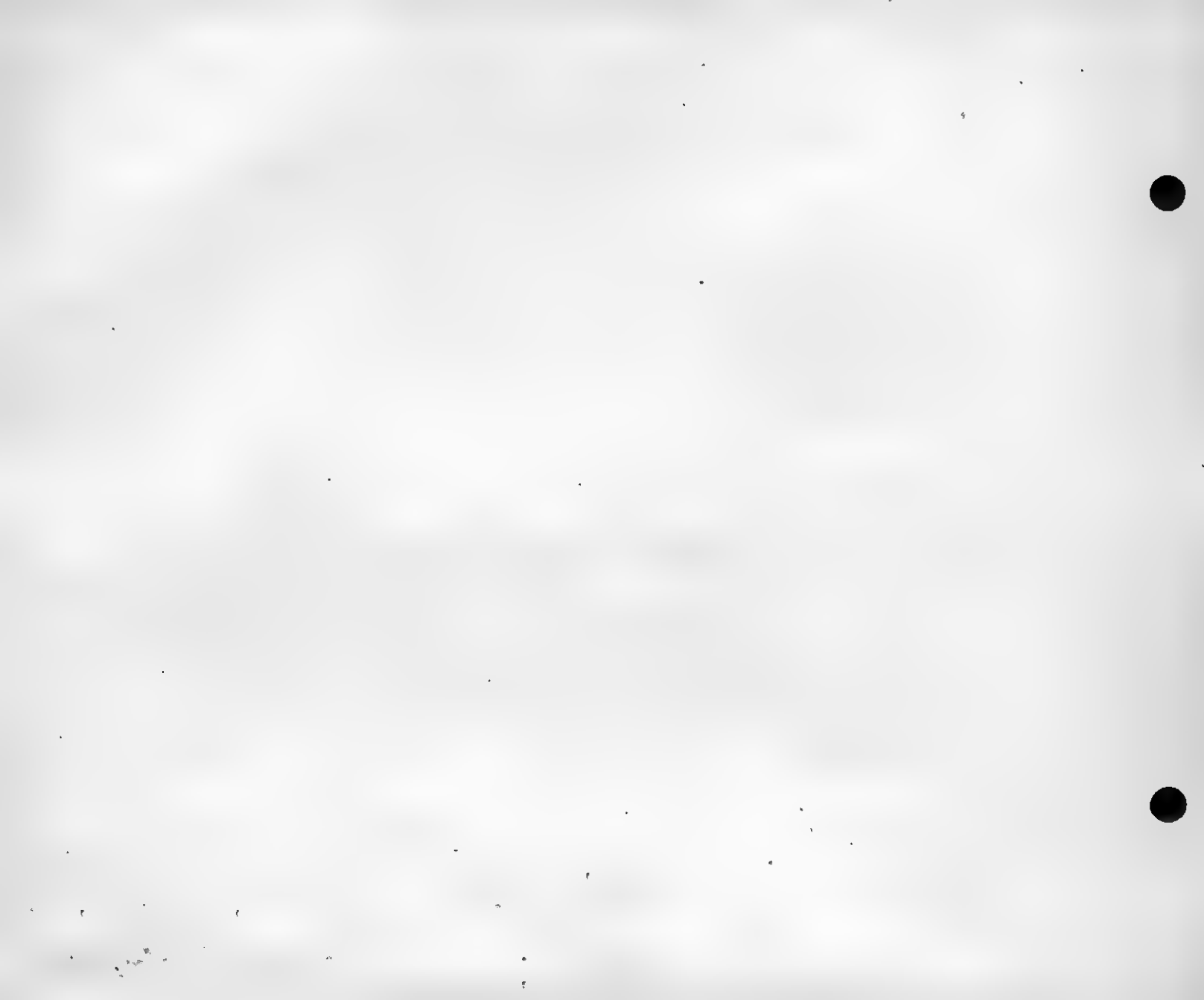
07098

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07094

1 DECEASED NAME (Type or Print) <i>Ellen Clarissa Hosh</i>			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5 19 1969			2b HOUR 12:30 AM		
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>Feb 7, 1964</i>	6 AGE in years (last birthday) <i>5</i> YRS	IF UNDER 1 YEAR MONTHS <i>3</i> DAYS <i>10</i>	IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	2c DATE PRONOUNCED DEAD Month <i>May</i> Day <i>19</i> Year <i>1969</i>		
7a BIRTHPLACE (State or foreign country) <i>Md</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Infant</i>		12b KIND OF BUSINESS OR INDUSTRY
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>			13b COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Rockville</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>Frank</i> Middle <i>Delano</i> Last <i>Hosh</i>			15. MOTHER'S MAIDEN NAME First <i>Ruth</i> Middle <i>Turner</i> Last <i></i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		
16b SOCIAL SECURITY NO			17 INFORMANT <i>Matthew</i>			17 ADDRESS <i>Same as above</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> <i>911X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Aspiration of Gastric Contents</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 MIN</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year <i>12:30 AM 5/19 1969</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Aspirated food while about 1/2 hr after eating</i>		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>			21f LOCATION Street or R.F.D. No. City or Town County State <i>1012 Paul Dr Rockville Montgomery Md</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>May 19, 1969</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, EMBALMING (Type) <i>Burial</i>			23b DATE <i>5/20/69</i>			23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		
24 FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>			ADDRESS <i>1331 Rock Pike Rockville, Maryland</i>			25a REC'D BY REGISTRAR DATE <i>MAY 22 1969</i>		
						25b REGISTRAR'S SIGNATURE <i>Charles Jung</i>		



FOR STATE
HEALTH DEPT.

07099

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07095

1 DECEASED-NAME (Type or Print) James F.		First James F.		Middle Hassett		Last Sr.		2a. DATE KNOWN OF ESTI- DEATH MATED 5-14		Month 5 Day 14 Year 1969		2b. HOUR 10:30	
3 SEX Male		4 RACE W		5 DATE OF BIRTH 7/17/95		6 AGE (in years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD Month 5 Day 14 Year 1969	
7a BIRTHPLACE (State or foreign country) Wash, DC		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH St. Montg.							
10 CITY OR TOWN OF DEATH Silver Spring				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bricklayer				12b KIND OF BUSINESS OR INDUSTRY -	
13a USJA. RESIDENCE (Where deceased lived if institution Residence before admission) STATE MD				13b COUNTY Howard		13c CITY OR TOWN Ellicott City		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 6604 Allen Lane			
14. FATHER'S NAME First Michael Middle ? Last Hassett				15. MOTHER'S MAIDEN NAME First Bridget Middle ? Last Shae									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b SOCIAL SECURITY NO 577-12-1855A		17 INFORMANT James F. Hassett Jr.				ADDRESS 9218-St. Andrews Pl.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF with Heart Block Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last Chronic Atherosclerotic Heart Disease (b) Chronic Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Atherosclerotic Heart Disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Keap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED May 14, 1969					
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 5/17/69				23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.				23d LOCATION (City or Town) (County) (State) Wash., D.C.	
24. FUNERAL DIRECTOR Walley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland				REC'D BY REGISTRAR DATE MAY 19 1969				25b REGISTRAR'S SIGNATURE R. Jones	

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 07100												MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												07096			
1 DECEASED-NAME (Type or print) First Middle Last Frederick William Heine						2a. DATE OF DEATH Month Day Year May 26 1969						2b. HOUR 6:35 AM															
3 SEX Male		4 RACE White		5. DATE OF BIRTH January 20, 1893				6 AGE (In years last birthday) 76 YRS.		7E UNDER 1 YEAR MONTHS DAYS HOURS MIN		7F UNDER 24 HRS HOURS MIN															
7a BIRTHPLACE (State or foreign country) Dist. of Columbia		7b CITIZEN OF WHAT COUNTRY? U.S. America		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md																					
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San + Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Real Estate Sales				12b KIND OF BUSINESS OR INDUSTRY Real Estate																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		3d INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 311 Lanark Way																			
14 FATHER'S NAME First Middle Last Frederick Heine				15. MOTHER'S MARDEN NAME First Middle Last Emma Simpers																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO 577-18-4679		17 INFORMANT Fred W. Heine, Jr.		17 Address 9705 Southern Blvd. Silver Spring, Md.																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4107 Acute Anteroseptal Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last TWO days Several years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus																											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from 5-15, 1969, to 5-26, 1969, that (I) (we) last saw the deceased alive on 5-25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE Stuart L. Nelson		22c. DATE SIGNED 5-26-69		22d. PHYSICIAN'S NAME (Type) Stuart L. Nelson																							
22e. ADDRESS 831 Univ. Blvd. East. Silver Spg. Md.																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Mont., Maryland		24. FUNERAL DIRECTOR E. Murphy, Inc. Silver Spring, Md.																			
25a. REC'D BY REGISTRAR JUN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge																									

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

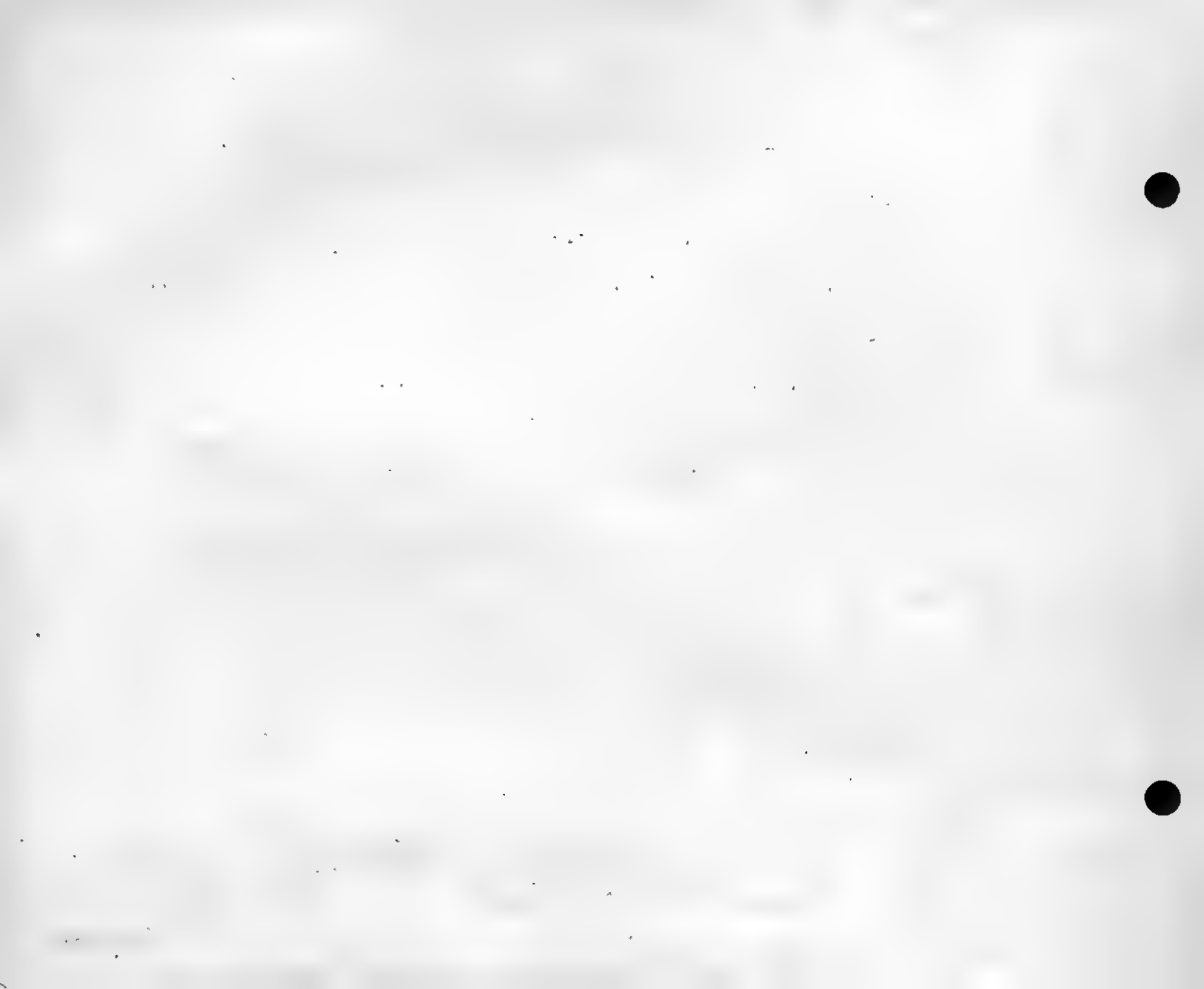
07101

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07097

1 DECEASED NAME (Type or Print)		First James		Middle Albert		Last Herbert		2a DATE KNOWN OF DEATH		Month 5		Day 20		Year 1969		2b HOUR 9:05 AM							
3 SEX	M	4 RACE	W	5 DATE OF BIRTH	9-1-93		6 AGE (in years last birthday)	75 YRS		F UNDER MONTHS		YEAR DAYS		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD							
7a BIRTHPLACE (State or foreign country)		MARYLAND		7b CITIZEN OF WHAT COUNTRY?		US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery													
10 CITY OR TOWN OF DEATH Takoma Park, Md.				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital solve street address) Wash. San & Hosp				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED				12b KIND OF BUSINESS OR INDUSTRY											
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				Md.				13b COUNTY				Pr. Geo.				13c CITY OR TOWN							
												13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER							
																9302 Adelphi Rd. Adelphi, Md.							
14 FATHER'S NAME						First John						Middle Franklin						Last Herbert					
15 MOTHER'S MAIDEN NAME						First Addie						Middle Sarah						Last Dean					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO						17. INFORMANT						ADDRESS					
						156 1. 2r						220-44-2365						sister Mrs. A. Blair					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																							
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>																							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerotic Heart Disease</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
MEDICAL CERTIFICATION																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No City or Town County State											
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE						Belden R. Reap M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type)						Belden R. Reap M.D.						ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>											
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
												ADDRESS (Street, city, town, county)											
												22b DATE SIGNED MAY 20, 1969											
23a BURIAL, CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
BURIAL				5/23/69				MTH. OLIVET				WASH., D.C.											
24 FUNERAL DIRECTOR												25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
JAS. T. RYAN, INC. 317 PA. AVE., S.E. WASH., 20002, D.C.												MAY 23 1969		Charles Judge									



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07098

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR	
LEON		M.	HERMAN		5 31		1969	4 25	PM		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		
Male	White	1/26/05		64 YRS	MONTHS DAYS		HOURS MIN		Month Day Year		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH					
Poland		U. S.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a JSLA. OCCUPATION (Kind of work done during most of work'ng life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hosp.			Economist			U.S. Gov.		
13a JSLA. RESIDENCE (Where deceased lived, if instituton Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d STREET AND NUMBER		
Md.			Montgomery Sil. Sp.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Brunett Ave.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
Jacob			Herman			Mollie --			ADDRESS Sil. Sp, Md.		
Augusta Herman			10027 Brunett Ave.								
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute Sudden</u>											
4124 DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Cardio Vascular Disease</u> years											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIT ON GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 8)			
				HOUR A.M. P.M. 19							
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>											
ACTUAL SIGNATURE		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED			
EXAMINER'S NAME (Type)		John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		May 31, 1969			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county)			
23a BURIAL, CREMATION REMOVA. (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		6/3/69		King David Mem.Gar.		Falls Church, Va.					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Bernard Danzansky & Sons				-3501 14th St. N.W. Wash., D.C.				5 1969		Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07103		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07099	
Items 11 & 16		Film 413 6/4/69 kk		CERTIFICATE OF DEATH	
1. DECEASED NAME (Type or print) First Middle Last Leo IngeMANN HIGHBY			2a. DATE OF DEATH Month Day Year MAY 18 1969		2b. HOUR 11 A M
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/30/01	
7a. BIRTHPLACE (State or foreign country) Minn.		7b. CITIZEN OF WHAT COUNTRY? America		6. AGE (In years last birthday) 67 YRS.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor La. Nur. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) State Dept. Official	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME First Middle Last Lars P. Highby		15. MOTHER'S MAIDEN NAME First Middle Last Anna Hansen		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	
17. INFORMANT Mrs. Elizabeth P. Highby - wife		18. SOCIAL SECURITY NO. 578-32-4097M		19. ADDRESS Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>CEREBRAL ARTERIO-SCLEROSIS</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>WITH BRAIN ATROPHY</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT</u> , 19 <u>68</u> , to <u>MAY</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Sarah E. Glover M.D.</u>				22c. DATE SIGNED 5-18-69	
22d. PHYSICIAN'S NAME (Type) SARAH E. GLOVER M.D.				22e. ADDRESS 10128 CEDAR LANE Kensington Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 5-21-69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.		25a. RECD BY REGISTRAR MAY 23 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07104

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07100

1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month 5 Day 22 Year 69			2b HOUR 9:10A ^M		
CLAUDE			NMN			HOBBS					
3. SEX MALE			4. RACE WHITE			5 DATE OF BIRTH 7-12-83			6 AGE (In years last birthday) 85 YRS.		
									IF UNDER 1 YEAR MONTHS DAYS		
									IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY		
MARYLAND			USA						Md.		
10 CITY OR TOWN OF DEATH OLNEY			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CATTLE DEALER			12b KIND OF BUSINESS OR INDUSTRY LIVESTOCK		
13a U.S.A. RESIDENCE (Where deceased lived, if institution- admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MARYLAND			MONTGOMERY			SILVERSPRING			13e STREET AND NUMBER 13309 SHERWOOD FOREST DRIVE		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
FRANKLIN			-			HOBBS			MARTHA		
									JOHNSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO 578-48-6305			17 INFORMANT MEDICAL RECORD DEPT.			Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy, thrombotic</u> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anterior subarachnoid hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 Months 10 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1965, to May, 1965, that (I) (we) last saw the deceased alive on 5/22/65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE A. D. Bonifant						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.						22e. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.					
23a B. RIAL, CREMATION, REMOVAL (Specify)			23b DATE 5-26-69			23c NAME OF CEMETERY OR CREMATORY Colesville			23d LOCATION (City or Town) (County) (State) Colesville Mont. Md.		
Burial											
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.						25a REC'D BY REGISTRAR MAY 26 1969			25b REGISTRAR'S SIGNATURE Charles George		

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

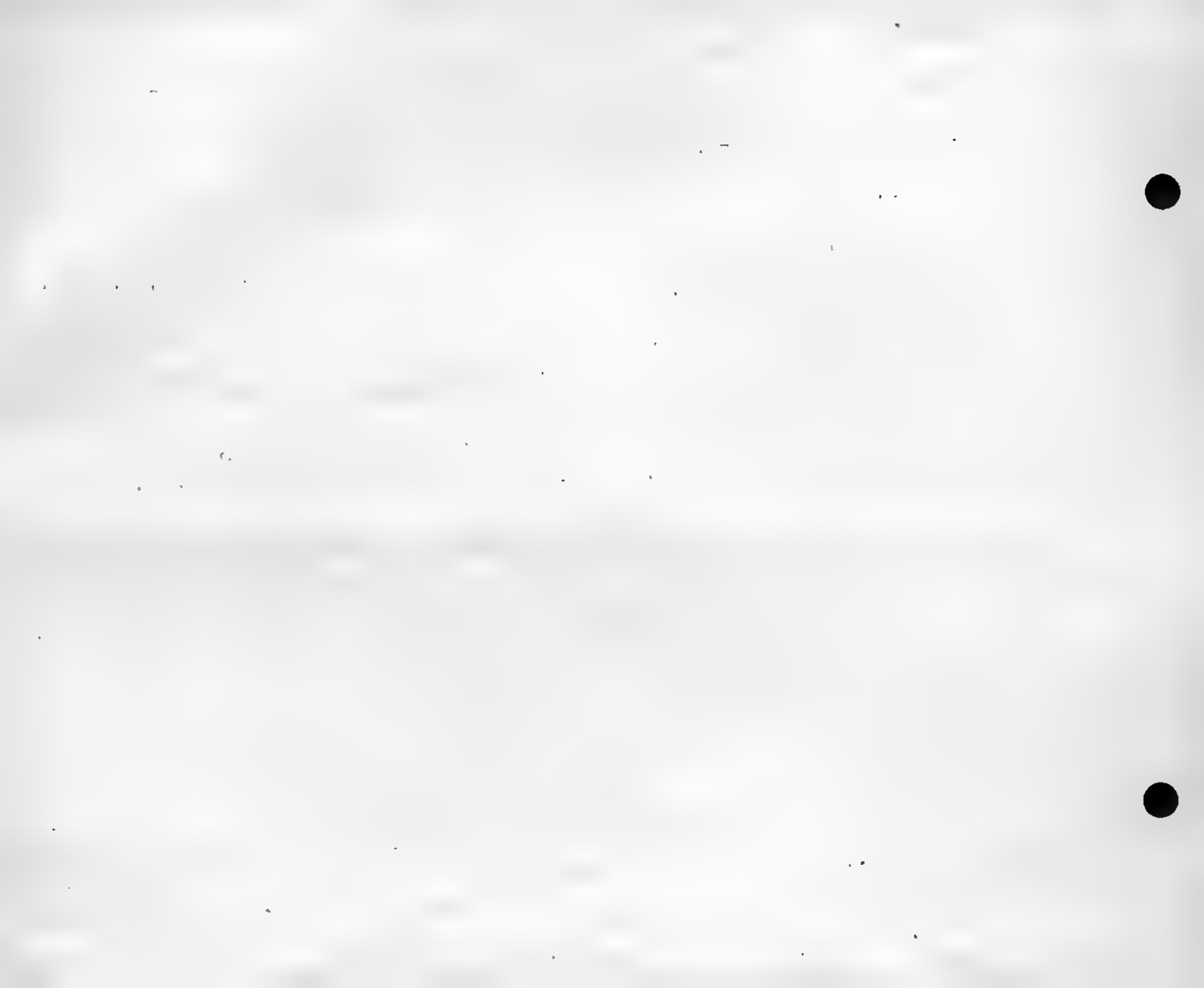
07105

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Hazel Hill			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> MATED <input type="checkbox"/> 5-12-69			2b HOUR 1:25 PM			
3 SEX F	4 RACE W	5 DATE OF BIRTH 1-27-1899	6 AGE (In years at birthday) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 5 Day 12 Year 1969			2d HOUR 1:25 PM			
7a. BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Takoma Park,			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash San & Hosp			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b CITY OR TOWN Mont.		13c CITY OR TOWN		3d INSIDE CITY, APTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER # 8 Travis Dr. T.P., Md.			
14 FATHER'S NAME First George Middle Will. Last Will.			15 MOTHER'S MAIDEN NAME First Kate Middle McAvailable Last McAvailable									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT Dr. R. Roberts			ADDRESS 17506 - 2nd Farm Dr.			
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Belden R. Neap			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED May 12, 1969			
EXAMINER'S NAME (Type) BELDEN R. NEAP, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City, County, State) Adelphi P. Co. Md.			
23a. B. BURIAL CREMATION REMOVAL (Specify)			23b. DATE May 15-1969			23c. NAME OF CEMETERY OR CREMATORY Garage Hill Cem.			23d. LOCATION (City or Town) (County) (State) Adelphi P. Co. Md.			
24. FUNERAL DIRECTOR Arthur Watters			ADDRESS 254 Carroll St - N.E.			25a. REC'D BY REGISTRAR DATE MAY 15 1969			25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07106

CERTIFICATE OF DEATH

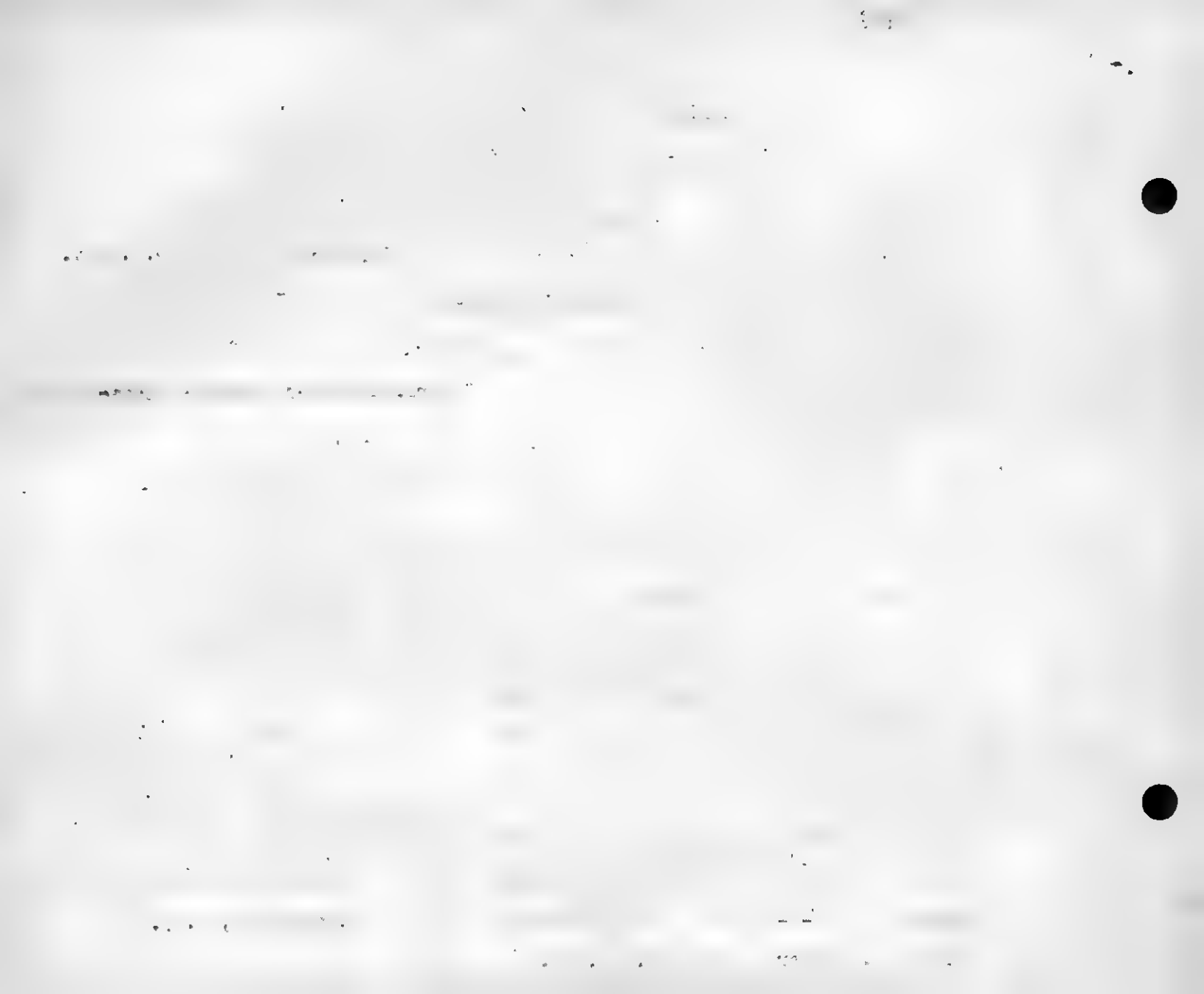
07102

1 DECEASED NAME (Type or print) <i>William K Hodges</i>			2a DATE OF DEATH Month <i>May</i> Day <i>1</i> Year <i>1969</i>			2b. HOUR M <i></i>			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>5/16/03</i>		6 AGE (In years last birthday) <i>66</i> YRS		7 IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i>	
7a BIRTHPLACE (State or foreign country) <i>West D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Supervisor</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Telephone</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Kenington</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10225 Kenington Pkwy</i>	
14 FATHER'S NAME First <i>Louis</i> Middle <i>O</i> Last <i>Hodges</i>			15 MOTHER'S MAIDEN NAME First <i>Ethel</i> Middle <i></i> Last <i>Kirkus</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO <i></i>			17 INFORMANT <i>Wife Maureen Hodges</i>			Address <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>									2 weeks
DUE TO, OR AS A CONSEQUENCE OF <i>Coronary arteriosclerosis with thrombosis</i>									
DUE TO, OR AS A CONSEQUENCE OF <i></i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSISTENT IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i>19</i> Year <i>69</i> P.M. <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>				
22a. I certify that (I) (the hospital) attended the deceased from <i>April 16</i> , 19 <i>69</i> , to <i>May 1</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>MAY 1</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Joseph P. Connor, M.D.</i>		22c. DATE SIGNED <i>May 2, 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>JOSEPH P. CONNOR</i>					
22e. ADDRESS <i>9420 OLD GEORGETOWN RD.</i>									
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-5-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Rockville Mont Md</i>			
24. FUNERAL DIRECTOR <i>Robert A Pumphrey Bethesda, Maryland</i>		25a RECD BY REGISTRAR <i>MAY 7 1969</i>		25b REGISTRAR'S SIGNATURE <i>William J. Gudge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 07107 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07103 </div> <div style="display: flex; justify-content: space-between;"> Item 5 Film 412 5/12/69 kk CERTIFICATE OF DEATH </div>											
1. DECEASED NAME (Type or print) <u>Anna Pauline Holdridge</u>						2a. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1969</u>		2b. HOUR <u>5:45</u> P.M.			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>July 18, 1914</u>		6. AGE (In years last birthday) <u>74</u> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.					
10. CITY OR TOWN OF DEATH <u>Wheaton</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kangaroo D.D.S. Nursing Home</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Librarian</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md</u>				13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Brookeville</u>		13d. INSIDE CITY, IN TSP? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>-</u>	
14. FATHER'S NAME First <u>Eugene</u> Middle <u>Holdridge</u> Last <u>Holdridge</u>				15. MOTHER'S MAIDEN NAME First <u>Anna</u> Middle <u>Johnson</u> Last <u>Johnson</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16b. SOCIAL SECURITY NO. <u>220-44-1099-T</u>		17. INFORMANT <u>Mrs. Alexander Casanges</u> Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Malnutrition</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>several years</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 69</u> to <u>May 19 69</u> , that (I) (we) lost saw the deceased alive on <u>April 20 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard A. Yates</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/4/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>R. A. YATES</u>				22e. ADDRESS <u>OLNEY, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-7-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>				23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> <u>Laytonville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07108

07104

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First Middle Last <i>James Ellsworth Holland</i>			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <i>May 7 1969</i>			2b HOUR <i>8:30 PM</i>		
3 SEX <i>male</i>		4 RACE <i>colored</i>		5 DATE OF BIRTH <i>Oct 6, 1934</i>		6 AGE (In years last birthday) <i>34 YRS</i>		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year <i>May 7 1969</i>	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>					
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>Laborer</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>				13b COUNTY <i>Mont. Rockville</i>				13c STREET AND NUMBER <i>King's Farm - A. 355</i>			
14 FATHER'S NAME First Middle Last <i>UNKNOWN</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Pauline Holland</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT ADDRESS <i>Pauline Holland - 201 N. Adams St. Rockville, Md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pancreatitis Acute-Hemorrhagic</i> 30-1 DUE TO, OR AS A CONSEQUENCE OF Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute & Chronic Alcoholism</i> DUE TO OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John L. Bell</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <i>May 8, 1969</i>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE <i>5/12/69</i>				23c NAME OF CEMETERY OR CREMATORY <i>Lincoln Park</i>			
23d LOCATION (City or Town) (County) (State) <i>Rockville Montg, Md.</i>				23e RECD BY REGISTRAR <i>May 13 1969</i>				23f REGISTRAR'S SIGNATURE <i>John L. Bell</i>			
24 FUNERAL DIRECTOR <i>Robert L. Snowden Rockville, Md.</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07105											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR			
Jeffrey			Stephen			May		1969 Month 18 Day 1969 318P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR			
Male		Caucasian		August 22, 1960		8 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
California		USA				Montgomery		Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Naval Hospital			N/A					
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. ASIDE CITY LHM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Montgomery		Rockville		YES		604 Blossom Drive		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Bobby			F. Hollingsworth			Patricia		Marc-Aurele			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address			
No						CDR B. F. Hollingsworth, USCG, 604 Blossom		Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))											
PART 1 DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Anaplastic small cell tumor with widespread metastases</u>											
199.1 DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from May 12, 1969, to May 18, 1969, that (X) (we) last saw the deceased alive on May 18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Bernard Jay Bortz, MD						May 19, 1969					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Bernard Jay Bortz, MD						Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5-22-69		Arlington National		Arlington Arlington Va.					
24. FUNERAL DIRECTOR						25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Home Rockville, Maryland						MAY 23 1969		Charles Judge			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

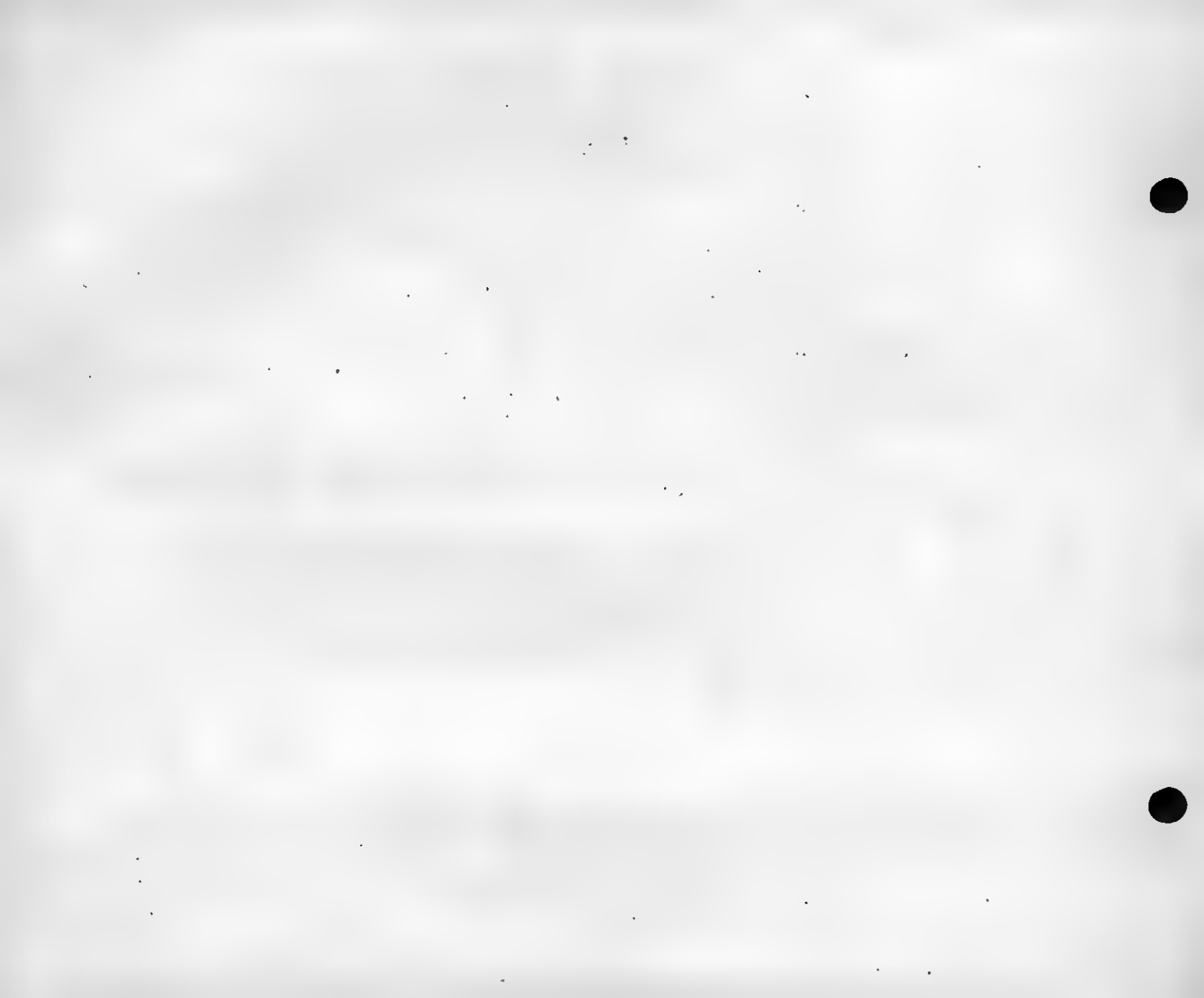
07110

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <i>Mary May Hopkins</i>			2a DATE KNOWN OF DEATH <i>5-26-69</i>			2b HOUR <i>12:35</i>		
3 SEX <i>F</i>	4 RACE <i>Cauc</i>	5 DATE OF BIRTH <i>May 24-1975</i>	6 AGE (in years) <i>94</i>	7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8 IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>5</i> Day <i>26</i> Year <i>69</i>		
7a BIRTHPLACE (State or foreign country) <i>Gen Bel Tenn</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2700 Barker St. House</i>			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RES DENCE (Where deceased lived at least 1 year before admission) STATE <i>MD</i>		13b COUNTY <i>Montg</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY (in 1957) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>2700 Barker St.</i>
14. FATHER'S NAME <i>Edward</i>			15 MOTHER'S MAIDEN NAME <i>Rushworth</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		
16b SOCIAL SECURITY NO <i>No</i>			16c INFORMANT <i>Edward R. Hopkins</i>			16d ADDRESS <i>10900 Northlake Dr. Bethesda Md</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		2e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County
22a. I certify that I took charge of the remains described above, held on death resulted from <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Belden R. Keap</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>5/26/1969</i>		
EXAMINER'S NAME (Type) <i>BELDEN R. KEAP, M.D.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE <i>May 29-1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Belton Co. Tenn</i>		23d LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR <i>Arthur Walters</i>			25 ADDRESS <i>254 Carroll St. Wash D.C.</i>		25a REC'D BY REGISTRAR <i>MAY 29 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completely filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1621

1

07111

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07107

1. DECEASED-NAME (Type or print) Douglas M First Hoyle Middle Hoyle Last			2a. DATE OF DEATH Month May Day 26 Year 1969		2b. HOUR M
3. SEX MALE		4. RACE White		5. DATE OF BIRTH Sept 25, 1903	
7a. BIRTHPLACE (State or foreign country) Travilah, Md		7b. CITIZEN OF WHAT COUNTRY? U.S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Rockville			
11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Stomach Valley North		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Rooper		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res before admn ssion) STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME Thomas		15. MOTHER'S MAIDEN NAME Martha McGruder		16. ADDRESS Rockville, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No.		16b. SOCIAL SECURITY NO 578-09-3764		17. INFORMANT Catherine U. Hoyle-1011 Rockcrest Dr.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Branchogenic Carcinoma 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH) BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from 10/12/1968 to 5/26/1969 , that (I) (we) lost the deceased alive on 5/24/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Robert C. Macon		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MFD DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/26/69	
22d. PHYSICIAN'S NAME (Type) Robert C. Macon		22e. ADDRESS 209 Viers Mill Rd, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Maryland		24. FUNERAL DIRECTOR Warner E. Humphrey, Inc., Silver Spring, Md.			
24a. REC'D BY REGISTRAR MAY 29 1969		24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

12 07112

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07108
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Anna Jewel Huddleston			2a. DATE OF DEATH Month 5 Day 7 Year 69			2b. HOUR 1:55 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-19-38		6. AGE (in years lost birthday) 31 YRS.		7. IF UNDER 1 YEAR MONTHS 31 DAYS 00 HOURS 00 MIN.		
7a. BIRTHPLACE (State or foreign country) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if instituton Res. before admission) STATE Md. COUNTY Prince Georges			13b. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET AND NUMBER 2914 73rd Ave.			
14. FATHER'S NAME First Robert Middle Cumby Last Morgan			15. MOTHER'S MAIDEN NAME First Mae Middle Morgan Last Morgan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 409-58-5711		17. INFORMANT Patients Hospital chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral edema, acute										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) Meningioma, tuberculoma sella										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION 23 Apr 69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Neoplasm			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 19 Month 4 Day 15 Year 69 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4/15 , 19 69 , to 8 May , 19 69 , that (I) (we) last saw the deceased alive on 8 May , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Arthur Huddleston			DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 8 May 69				
22d. PHYSICIAN'S NAME (Type) Arthur Huddleston			22e. ADDRESS 1015 Spring St. Silver Spring							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE 5/9/69		23c. NAME OF CEMETERY OR CREMATORY Funeral Home			23d. LOCATION (City or Town) (County) (State) Cookeville Putnam Tenn		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland						25a. REC'D BY REGISTRAR MAY 12 1969		25b. REGISTRAR'S SIGNATURE William Judge		

9911X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Graham			Hughes			May Month 23 Day 1969 or		837A M	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		Feb. 3, 1949		20 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D-VORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
New York		USA				Montgomery			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during usual working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Naval Hospital		USMC					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
New York		V		Rochester		YES <input type="checkbox"/> NO <input type="checkbox"/>		102 Mason Street	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William C. Hughes			Fern Tuckey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes		1968-69		088 44 4432		Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia with acute meningitis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>multiple fragment wounds</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. Mar 28 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) On duty					
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) --		21f. LOCATION Street or R.F.D. No. City or Town County State Republic of VietNam					
22a. I certify that (X) (this hospital) attended the deceased from Apr. 27, 1969, to May 23, 1969, that (X) (we) last saw the deceased alive on May 23, 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (I, D.) (all of us) view the body after death.									
22b. SIGNATURE <u>D. K. Roeder, MD</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 23 May 1969			
22d. PHYSICIAN'S NAME (Type) D.K. ROEDER, MD				22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-27-69				ROCHESTER NEW YORK			
24 FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W. Washington, D.C.				25a. RECEIVED BY REGISTRAR MAY 27 1969 DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

07114

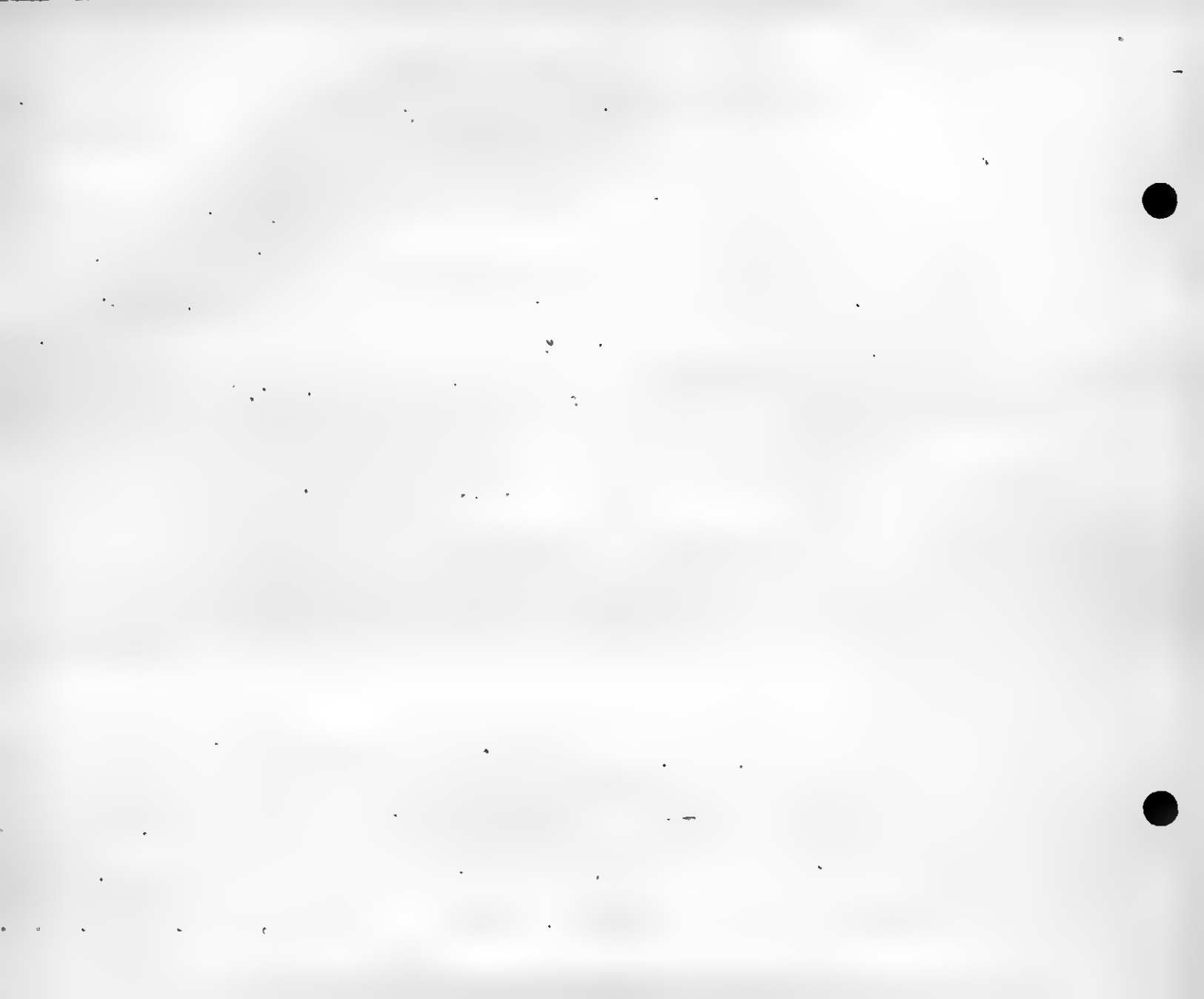
07110

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles Peter Hutterer			2a. DATE OF DEATH Month 5 Day 30 Year 69			2b. HOUR 6:25 AM	
3. SEX male		4. RACE white		5. DATE OF BIRTH 5-13-06		6. AGE (In years last birthday) 63 YRS	
7a. BIRTHPLACE (State or foreign country) Austria		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) ADMINISTRATOR		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md		13b. COUNTY montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6316 OWEN PLACE		14. FATHER'S NAME First MANFRED Middle HUTTRER Last STRASSBERG		15. MOTHER'S MAIDEN NAME First ANNA Middle STRASSBERG Last STRASSBERG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 098-12-6341		17. INFORMANT LUCY HUTTRER, WIDOW, SAME AS #13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <input type="checkbox"/>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 29 , 19 62 , to May 30 , 19 69 , that (I) (we) last saw the deceased alive on May 29 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE BLAINE H. EIG		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/30/1969			
22d. PHYSICIAN'S NAME (Type) BLAINE H. EIG		22e. ADDRESS 9401 Deerpark Circle, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 6-3-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co. Md.	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.		ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016		25a. REC'D BY REGISTRAR JUN 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



07115 Ella

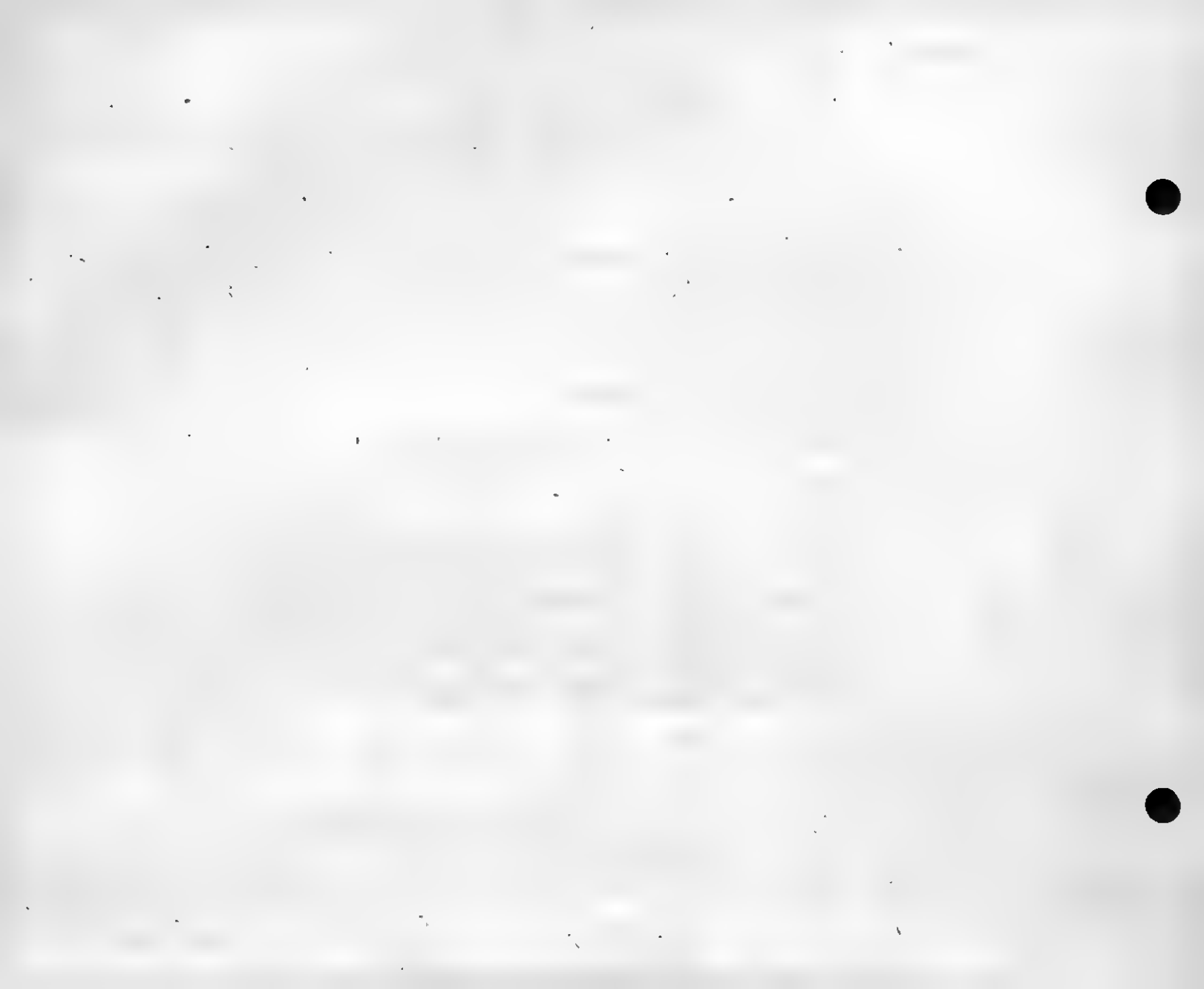
CERTIFICATE OF DEATH

07111

1. DECEASED-NAME (Type or print) First Middle Last Ella P. Ingram			2a. DATE OF DEATH Month Day Year 5 1 69			2b. HOUR 4:30 PM	
3 SEX F		4. RACE W		5. DATE OF BIRTH 2-7-1889		6. AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 8601 Manchester Rd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8601 Manchester Rd		14. FATHER'S NAME First Middle Last Rouis Palm		15. MOTHER'S MAIDEN NAME First Middle Last Hilda Hildebrand			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs Mary Ellen Murtagh Address 8601 Manchester Rd Silver Spring			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 2		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-28 , 19 67 , to 5-1 , 19 69 , that (I) (we) last saw the deceased alive on 4-7 , 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M Snow MD				DEGREE MD		22c. DATE SIGNED 5-2-69	
22d. PHYSICIAN'S NAME (Type) M SNOW MD				22e. ADDRESS 9013 FLOWER Silver			
23a. BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE 5/3/69		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Bladensburg Rd. Md.	
24. FUNERAL DIRECTOR W. C. Harshbarger Inc.		ADDRESS 8455 B & A Ave		25a. REC'D BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <i>Esther May Ingram</i>					2a. DATE OF DEATH <i>MAY</i> Month <i>4</i> Day Year <i>69</i>			2b. HOUR <i>1p.</i> M		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>7-29-98</i>		6 AGE (In years last birthday) <i>70</i> YRS		7 UNDER 1 YEAR MONTHS <i>11</i> DAYS <i>24</i>		
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>AMERICAN</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md				
10 CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WASH SAN & Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSE</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>PR GEO</i>		13c. CITY OR TOWN <i>HYATTSVILLE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7401 NEW HAMPSHIRE AVE</i>	
14 FATHER'S NAME First <i>Francis</i> Middle <i>Homer</i> Last <i>Melick</i>			15. MOTHER'S MAIDEN NAME First <i>Etoile</i> Middle <i>Crandall</i> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <i>577-01-0112D</i>		17 INFORMANT <i>PTs</i> Address <i>Chart</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>									<i>3hr.</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auricular fibrillation</i>									<i>1mo.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Hypertensive heart disease</i>									<i>old</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 1969, to <i>May 4</i> , 1969, that (I) (we) last saw the deceased alive on <i>May 4</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Ernest A. Sarao M.D.</i> DEGREE <i>M.D.</i>					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>5/4/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>ERNEST A. SARAO M.D.</i>					22e. ADDRESS <i>7006 NEW HAMPSHIRE AVE Takoma Park</i>					
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 7, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION (City or Town) <i>Arlington</i> (County) <i>Virginia</i> (State)				
24. FUNERAL DIRECTOR <i>Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>MAY 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4411

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
BESSIE			SICKLE INOFF			Month Day Year MAY 27 1969			30 38 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		HEBREW-WHITE		12/10/1999		69 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.		
RUSSIA		U.S.A.				MONTGOMERY					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING			HOLY CROSS			HOUSEWIFE					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.			MONTG.		SILVER SPRING				1017-STROUT, S.T.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
HARRY			SICKLE			UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO			NONE		WM. SICKLE			1017-STROUT, ST.			S.S. MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RUPTURED DISSECTING ANEURYSM THORACIC AORTA										24 Hrs.	
4411 DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 26 May, 1969, to 27 May 1969, that (I) (we) last saw the deceased alive on 27 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE Eugene P. Librie MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 27 May 1969			
22d. PHYSICIAN'S NAME (Type) EUGENE P. LIBRIE						22e ADDRESS 10400 CONN. AVE. KENNINGTON MD.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
BURIAL		5/28/69		OHEV-SHELOM-CEM.		WASH.				D.C.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
GOLDBERG FUNERAL HOME				421 N. W. ST.		MAY 28 1969		J. Charles Judge			

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1

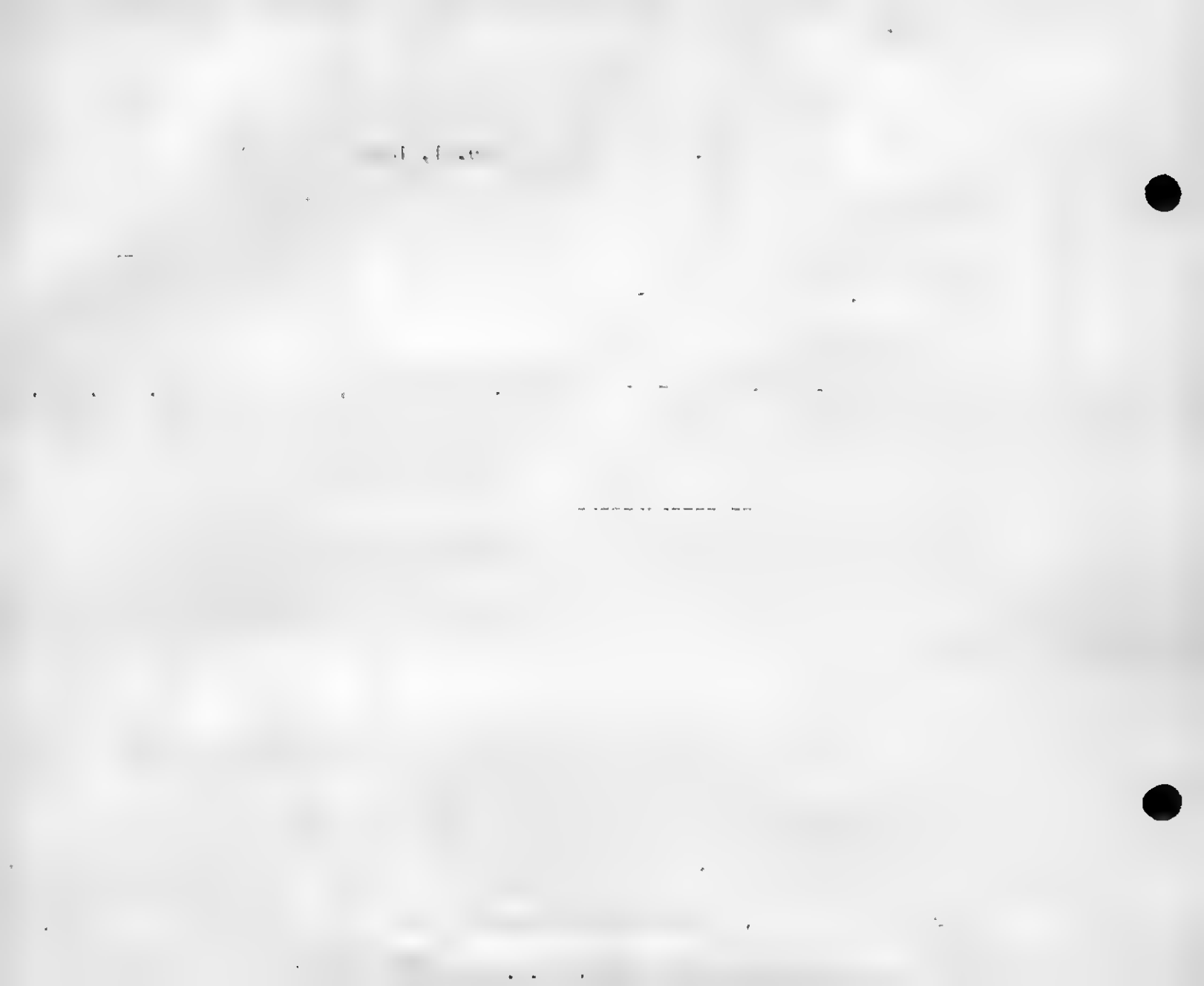
07118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07114

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Dora Isard			2a. DATE OF DEATH Month Day Year May 19 1969			2b. HOUR 11 AM			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH Feb. 21, 1890		6. AGE (in years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Carriage Hill ECF		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY -----		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1425 Manchester Lane, N. W.	
14. FATHER'S NAME First Middle Last Harry Fulmer			15. MOTHER'S MAIDEN NAME First Middle Last Jennie ? ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO 087-16-6711-B		17. INFORMANT Address Mrs. Hilda Bloom, 1119 Quebec St. Sil. Spr. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction (probable) DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF -- (c) With congestive heart failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10 Nov 1968 , to 19 May 1969 , that (I) (we) saw the deceased alive on 17 May 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald B. Doty				DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 19 May 69	
22d. PHYSICIAN'S NAME (Type) Dr. Donald B. Doty				22e. ADDRESS 1909 Hanover Street, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 21, 1969		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) (County) (State) Falls Church Va.			
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th St., N.W.				25a. REC'D BY REGISTRAR MAY 23 1969		25b. REGISTRAR'S SIGNATURE William A. Underhill			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First Emma		Middle Porter		Last Jackson		2a. DATE OF DEATH 5 Month 25 Day 1969		2b. HOUR 12:43 A	
3 SEX Female		4 RACE white		5 DATE OF BIRTH 2-13-78		6 AGE (in years last birthday) 91 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) San.arium + Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House wife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13b. COUNTY Chillum		13c. CITY OR TOWN Chillum		13d. INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 906 Somerset Pl.			
14 FATHER'S NAME First Adam		Middle thomson		Last thompson		15 MOTHER'S MAIDEN NAME First Ellen		Middle Ellen		Last Spear	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO UNKNOWN		17 INFORMANT Address Wash. San + Hospt. Med. records Takoma Park, Md							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Intestinal obstruction 153.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the colon DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 hours Known 2 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from May 23, 1969 , to May 25, 1969 , that (I) (we) last saw the deceased alive on May 24, 1969 , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Aaron H. Traum M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED May 25, 1969					
22a. PHYSICIAN'S NAME (Type) AARON H. TRAUM		22e. ADDRESS 5237 Georgia Ave Silver Spring Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Calver Manor Park Md					
24. FUNERAL DIRECTOR Takoma Funeral Home		ADDRESS Washington DC		25a. RECEIVED BY REGISTRAR DATE MAY 27 1969		25b. REGISTRAR'S SIGNATURE William J. Jones					

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07120

07116

1 DECEASED-NAME (Type or print) First Middle Last John August Johansson			2a. DATE OF DEATH Month Day Year 6 14 69			2b. HOUR 7:00 A.M.	
3 SEX M		4. RACE Amer. - White		5. DATE OF BIRTH 9-15-94		6. AGE (In years last birthday) 74 YRS	
7a. BIRTHPLACE (State or foreign country) Sweden		7b. CITIZEN OF WHAT COUNTRY? Amer. U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & H		2a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. since before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 708 Hankin St.		14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S M maiden NAME First Middle Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myelomonocytic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF <u>2 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/3</u> , 19 <u>69</u> , to <u>5/17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Israel Spector MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/17/69</u>			
22d. PHYSICIAN'S NAME (Type) Israel Spector		22e. ADDRESS 911 Silver Spring Ave. Silver Spg Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/24/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges County Md.	
24. FUNERAL DIRECTOR <u>The H. Hines Co</u>		ADDRESS <u>2801 14th St NW</u>		25a. REC'D BY REGISTRAR DATE MAY 21 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1743

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
07121											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Marjorie Evelyn JONES						2a. DATE OF DEATH Month Day Year May 28 1969			2b. HOUR 1:15 M		
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH 10 October 1922		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Beth Md				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. US. AL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Fairfax		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3122 Wynford Dr.			
14. FATHER'S NAME First Middle Last Kenneth J Hicks						15. MOTHER'S MAIDEN NAME First Middle Last Iona Schaffer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No				16b. SOCIAL SECURITY NO 506-18-8441		17. INFORMANT Address Frank R. Jones 3122 Wynford Dr. Fairfax Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ca of Breast</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that Dr. (this hospital) attended the deceased from 7 May, 1969, to 28 May, 1969, that he (we) last saw the deceased alive on 28 May 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (not) view the body after death.											
22b. SIGNATURE A. L. Graybiel						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 28 May 1969			
22d. PHYSICIAN'S NAME (Type) A. L. GRAYBIEL, LCDR MC USN						22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE May 31, 1969		23c. NAME OF CEMETERY OR CREMATORY Memorial National Memorial Park Falls Church Fairfax Va.		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR COVINGTON MARTIN						ADDRESS FALLS CHURCH, VIRGINIA		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Jones	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07122

07118

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 13. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input type="checkbox"/> Month	Day	Year	2b. HOUR
Joseph William Jozefczyk					2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> May	7	1969	7:10 A
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	12-06-38		30 YRS.	MONTHS DAYS		HOURS MIN		Month 5 Day 7 Year 1969	2d. HOUR 7:51 A
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pa.		U.S.A.		Montgomery					Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Rockville						Asst. manager GELCO				
13a. USUAL RESIDENCE (Where deceased lived if institution residence before address on) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Mont.		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10607 Kenilworth Ave, Apt 101		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Joseph Jozefczyk					Clara Bartman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Same as Item 13.		
yes		1961		Unknown		Victoria Jozefczyk				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries Severe										Sudden
8120 DUE TO, OR AS A CONSEQUENCE OF (b) Trauma from auto accident										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		7:08 P.M. 5/7 1969		Car he was driving was struck by truck						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
		Highway		Montrose & Rockville Pike, Bethesda, Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		JOHN G. BALL				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5/7/69		
						ADDRESS (Street, city, town, or county)		Bethesda, Md.		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5-10-69		Monongahela Cemetery		Monongahela, Penna.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland						MAY 12 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

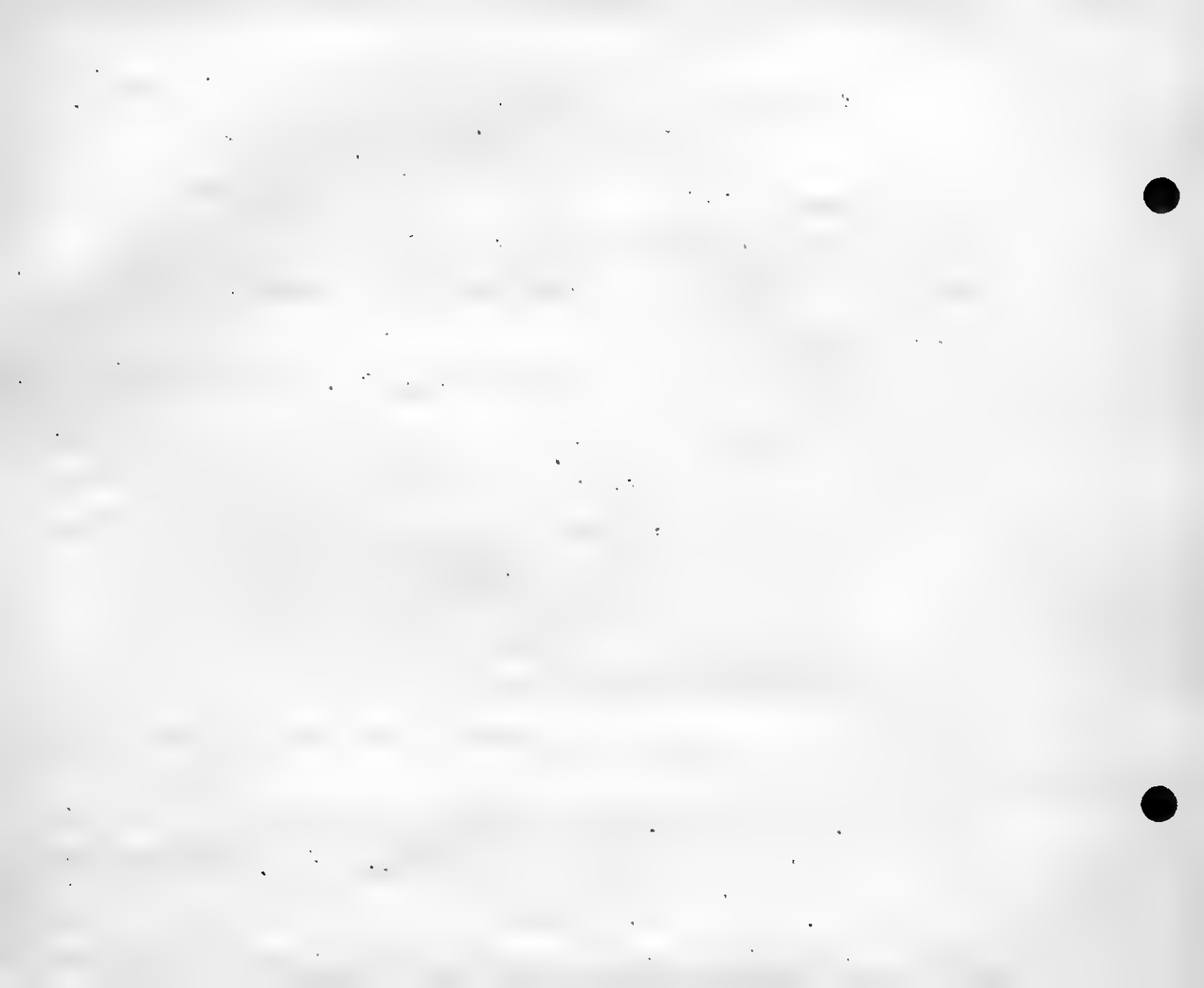
07123

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07119

Item 13 Film 6/13 6/3/69 kk

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Gertrude</i> First <i>Keren</i> Middle Last			2a. DATE OF DEATH Month <i>5</i> Day <i>25</i> Year <i>69</i>		2b. HOUR <i>1:34</i> P.M.
3. SEX <i>female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Nov. 27, 1915</i>		6. AGE (In years last birthday) <i>53</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Chelsea Mass</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Home of Greater Washington</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN (If outside CITY LIMITS?) <i>Rockville</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER <i>708 Sligo Ave. 6141 Montrose Rd.</i>	
14. FATHER'S NAME First <i>Kussel</i> Middle <i>Keren</i> Last			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Baicobitz</i> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Heinz J. Lorge, M.D., 6121 Montrose Rd. Rockville</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>492X Dilatation of heart due to overstrain</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Asthma</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>15 years</i> <i>25 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>Diabetes mellitus</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>April 1, 1968</i> , to <i>May 25, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 25, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Heinz J. Lorge, M.D.</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/25/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Heinz J. Lorge</i>		22e. ADDRESS <i>6121 Montrose Road, Rockville, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5/26/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ELES AVETRAD. CEM</i>	
23d. LOCATION (City or Town) (County) (State) <i>WASH. D.C.</i>		23e. FUNERAL DIRECTOR <i>Bernard Dangersky & Son</i>			
23f. ADDRESS <i>3501-14th St. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

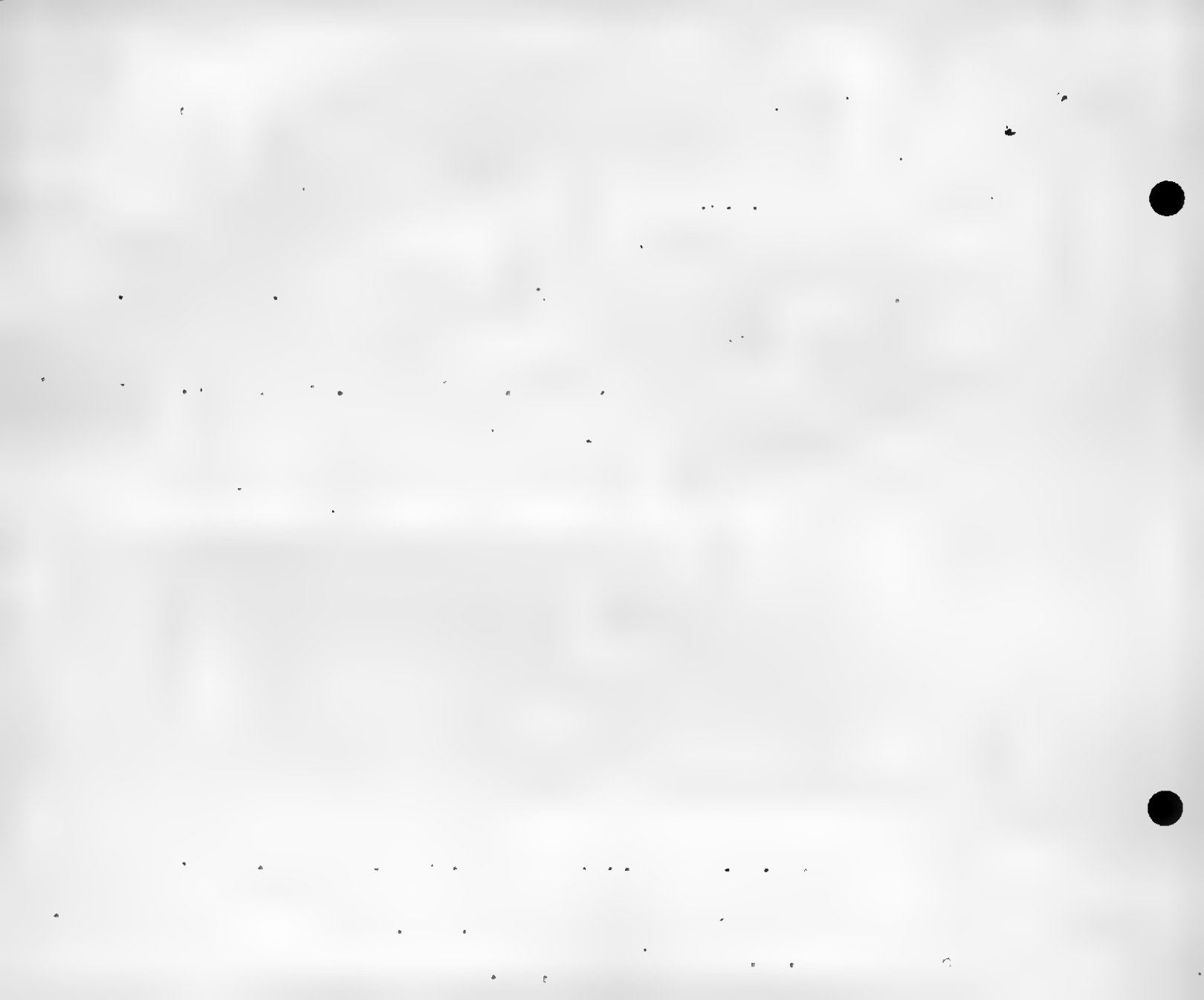
07124

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07120

CERTIFICATE OF DEATH

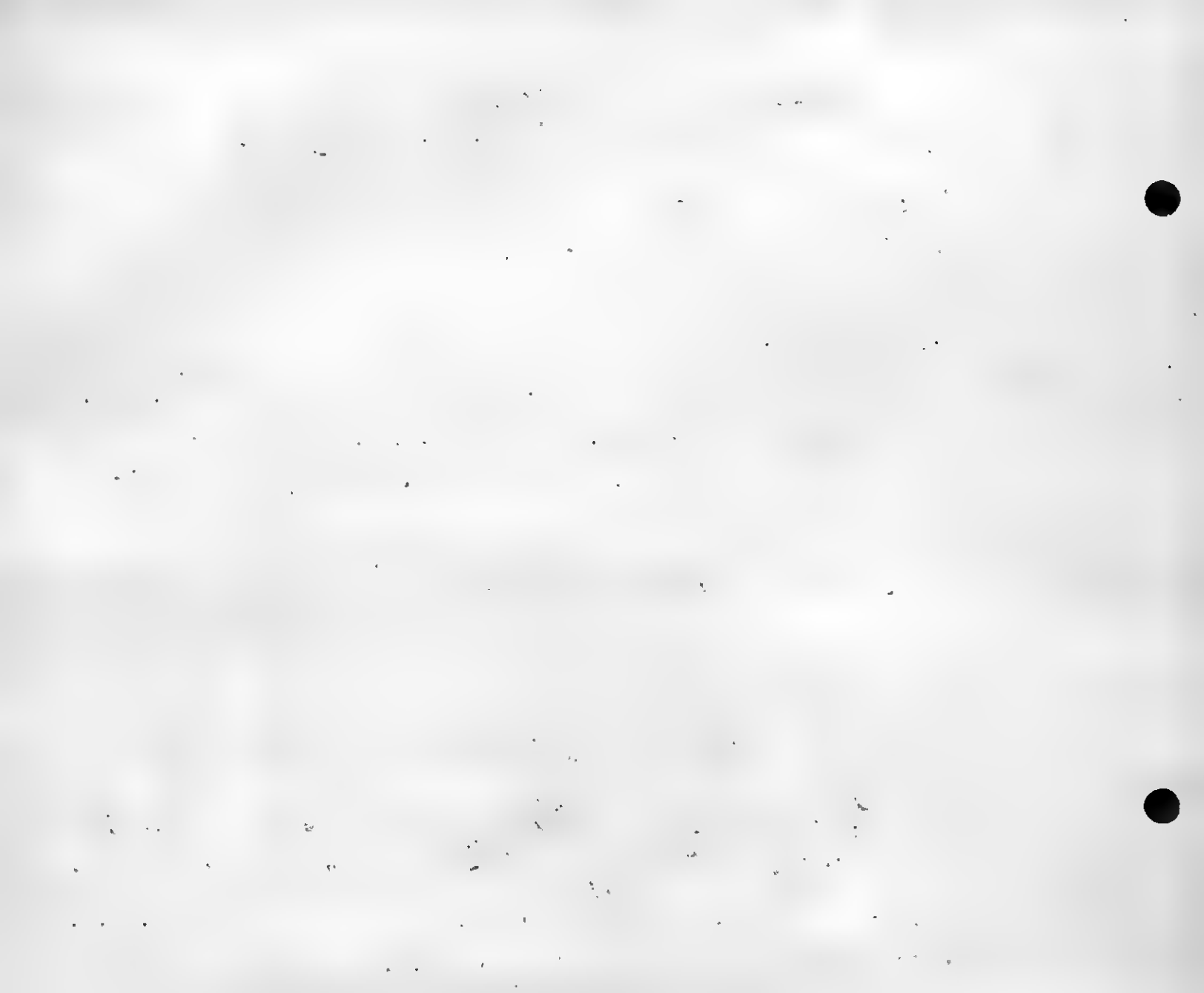
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
William				Kitt	May Month 16, 1969		M	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
Male	White		9/3/01		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Virginia		U.S.A.				Montgomery Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Olney		Montgomery General		Farmer		Farm		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM. IS?		13e. STREET AND NUMBER
Md.		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 N. Summit Ave.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
William				Kitt	Minnie Gullion			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address Md.		
NO		229 16 2031		Mr. Gullion		2 N. Summit Ave. Gaithersburg		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u> 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from April 19 69, to May 16 19 69, that (I) (we) lost the deceased alive on May 13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
C. I. Leal				Dr. L. I. Leal M.D.				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		N. Frederick Ave. Gaithersburg, Mary.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5/18/1969		Kimberling Luth. Cem.		Wythe Va.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Tyson Wheeler F. H.		1331 Rockville Pike Rockville, Md.		MAY 19 1969		J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) Jacob Kligman					2a. DATE OF DEATH May 28 1969		2b. HOUR 7:15 P.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH Nov 12, 1893		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hebrew Home - Aged			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE D.C.			13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2512 Eastern Ave. N.W.		
14. FATHER'S NAME First Yeskel Middle Kligman Last			15. MOTHER'S MAIDEN NAME First Toba Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Charles J. Kligman, Son, Both Address 3804 Radnor Rd. Md.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis, cerebral DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic cholecystitis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 16, 1969 to May 28, 1969 , that (I) (we) lost the deceased alive on May 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Heinz J. Lorge		22c. ADDRESS Hebrew Home of Greater Washington		22d. PHYSICIAN'S NAME (Type) Heinz J. Lorge		22e. DATE SIGNED May 28, 69			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/30/69		23c. NAME OF CEMETERY OR CREMATORY Ohev Shalom Talmud Torah - Wash., D.C.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Bernard Danzansky & Sons-3501 14th St. Wash., D.C. 20010		25a. REC'D BY REGISTRAR 3 1969		25b. REGISTRAR'S SIGNATURE Charles J. Kligman					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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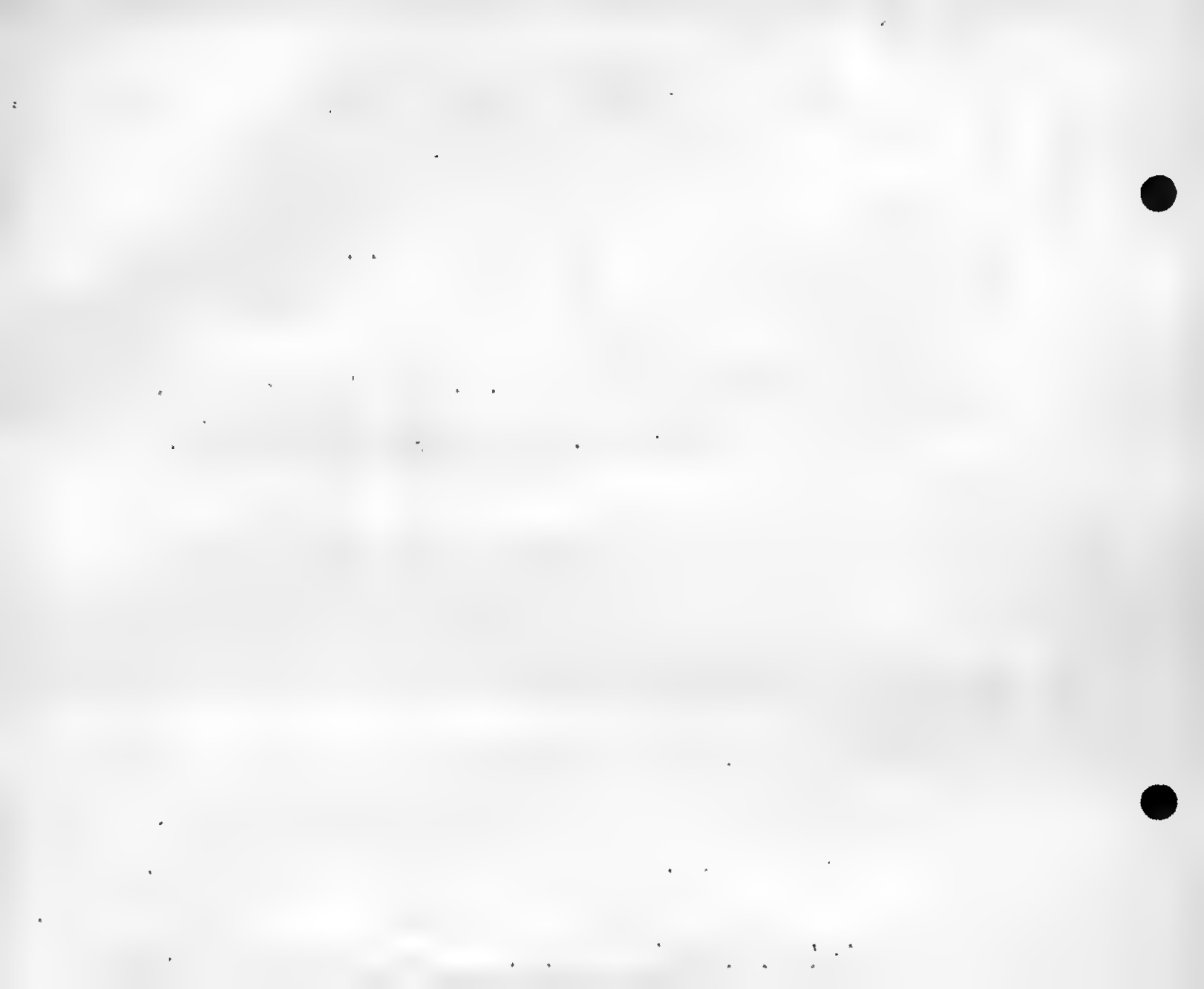
07126

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07122

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b. HOUR	
Pete		Joseph	KOZAR	May	Month	18 Day	1969	953A
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR MONTHS DAYS HOURS MIN.	
Male	Caucasian		July 22, 1921		47 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Ohio		USA				Montgomery Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Bethesda		Naval Hospital		U.S. Navy				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Florida		DUCAL		Jacksonville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4348 Woodmere Street
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Nicholas		Kozar	Marv	Luzeki				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
Yes		298 01 3783		Mrs. L. Kozar, 4348 Woodmere St.		Florida		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease and recent septal</u>								
DUE TO, OR AS A CONSEQUENCE OF <u>myocardial infarction</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 23</u> , 19 <u>69</u> , to <u>May 18</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 18</u> , 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Mitchell Mills</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>May 19, 1969</u>		
22d. PHYSICIAN'S NAME (Type) <u>Mitchell Mills, M. D.</u>				22e. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>5-23-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Va.</u>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u> ADDRESS <u>1400 Chapin St., N. W. Washington, D. C.</u>				25a. REC'D BY REGISTRAR <u>MAY 23 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. Judge</u>		



07127

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Ralph Middle H. Last KRAPP			2a. DATE OF DEATH Month 5 Day 4 Year 1969			2b. HOUR 7:45 M	
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 5-14-1889		6. AGE (In years (In years and days) 79 YRS.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda Silver Spring N.H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) District of Columbia		13b. COUNTY -		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4545 Conn. Ave. N.W.							
14. FATHER'S NAME First George Middle Krapp Last			15. MOTHER'S MAIDEN NAME First Jennie Middle Isaacs Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 060-0542867-A		17. INFORMANT Mrs. Anna Krapp, Widow, same as item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/23 , 19 67 , to 5/4 , 19 69 , that (I) (we) last saw the deceased alive on 5/3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S.W. Nealon Jr. M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/6/69	
22d. PHYSICIAN'S NAME (Type) S. W. Nealon Jr.				22e. ADDRESS 915 19th St. N.W., Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-7-1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery Co., Md.	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, 1 ADDRESS				25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Thomas J. Youdale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07128

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07124

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
ANNA			V.	KREISINGER	ESTIMATED		5	25	1969	7:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		Month	Day	Year
FEMALE	WHITE	VERMONT	80 YRS	MONTHS	DAYS	May 25		1969	7:30 P.M.	
7a. BIRTHPLACE (State or foreign country)		7b. COUNTRY OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
VERMONT		UNITED STATES		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		SUBURBAN HOSPITAL		HOUSEWIFE		AT HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Mont.		Bethesda		YES <input type="checkbox"/> NO <input type="checkbox"/>		4712 S. Chelsea La.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S M.A.DEN NAME		First	Middle	Last	
EUGENE				VAN ORMAN	NORA				GOODNOUGH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
NO				ROBERT KREISINGER, HUSBAND, SAME AS ITEM #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis, old and recent</u>										
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>Advanced Coronary arteriosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Cerebral infarct, old left cerebral</u>										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH		HOUR A.M. P.M.		19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED
<u>John G. Ball</u>		John G. Ball		M.D.						May 26, 1969
ADDRESS		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		5-28-1969		Cedar Hill Crematory		Suitland, Prince Georges Co., Md.				
24. FUNERAL DIRECTOR		JOSEPH GAWLER'S SON, INC.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		Md.		
5130 WISC. AVE., N. W. WASH., D. C. 20016				MAY 28 1969		Charles Judge				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07125

1 DECEASED NAME (Type or Print) <i>Thomas Burnett Lamb</i>		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5 30 1969		2b HOUR 9 35 M
3 SEX <i>MA</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>10/6/1910</i>	6 AGE (in years last birthday) <i>58</i> YRS	7c MONTHS <i>10</i> MONTHS
7a BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>
10 CITY OR TOWN OF DEATH <i>Wheaton</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2908 Parker Ave.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Steel-</i>
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <i>MD</i>		13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Wheaton</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME First <i>Patrick Lamb</i> Middle <i>Elizabeth</i> Last <i>Burnett</i>		15 MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Burnett</i> Last <i>Burnett</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <i>Mrs Dorothy Lamb, 2908 Park Ave, Wheaton Md.</i>
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Lacerations Multiple</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>gun shot wound through palate</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lost</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day, Year <i>9 35 P.M. 5/30 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <i>Shot Self with Rifle in mouth</i>
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f LOCATION Street or RFD No City or Town County State <i>2908 Parker Ave Wheaton Montgomery Md.</i>
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <i>May 31, 1969</i>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE <i>6/3/69</i>	23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	23d LOCATION (City or Town) (County) (State) <i>Pr Geo Co Md.</i>	
24 FUNERAL DIRECTOR <i>W. R. Huntzmann & Son,</i>		ADDRESS <i>5732 Georgia Wash D.C.</i>		25 REGISTRAR'S SIGNATURE <i>Phonetic Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07130

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07126

1. DECEASED-NAME (Type or print) First Middle Last Agnes Ashford LANE			2a. DATE OF DEATH Month Day Year May 2 1969			2b. HOUR P M 7:15 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH August 2, 1904		6. AGE (In years last birthday) 64 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 19 Wagner Street		14. FATHER'S NAME First Middle Last Snowden Ashford		15. MOTHER'S MAIDEN NAME First Middle Last Annette Crichton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 426-60-8495		17. INFORMANT Va. Beach, Va. James A. Metcalfe, 4001 Edinburgh Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST WITH MULTIPLE METASTASIS</u> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <u>7 Apr</u> , 19 <u>69</u> , to <u>2 May</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>2 MAY</u> , 19 <u>69</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Graybiel MD</u>		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4 MAY 1969	
22d. PHYSICIAN'S NAME (Type) LCDR A.L. GRAYBIEL, MC, USN		22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-5-69		23c. NAME OF CEMETERY OR CREMATORY St. Anne's Parish Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis Anne Arundel Maryland	
24. FUNERAL DIRECTOR John M. Taylor, 147-149 Gloucester, Annapolis		ADDRESS Maryland		25a. RECEIVED BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Joseph Francis Lavin						May 11, 1969			10 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.	
male		white		May 11, 1969		YRS MONTHS DAYS		HOURS MIN		1 9	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		United States				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution—residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery			Rockville				531 Brent Road	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
James Anthony Lavin			Margaret Catherine Tyrell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
						Mother					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain Aneurysm</u>											
777X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 11, 1969, to June 1, 1969, that (I) (we) last saw the deceased alive on May 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Marvin Tabb</u>						22c. DATE SIGNED <u>5/11/69 10 PM</u>					
22d. PHYSICIAN'S NAME (Type) <u>Marvin Tabb</u>						22e. ADDRESS <u>2401 Blue Ridge Ave Wheaton Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>5/19/69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>			23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>		
24. FUNERAL DIRECTOR <u>JMS. T. RYAN, Inc. J. Ryan</u>						25a. REC'D BY REGISTRAR <u>MAY 15 1969</u>			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07128

1. DECEASED-NAME (Type or print) Herbert Oliver Lee, Sr.			2a. DATE OF DEATH Month 5 Day 7 Year 69			2b. HOUR 8:25 ^A ^M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 7-11-10		6 AGE (In years last birthday) 58 YRS	
7a. BIRTHPLACE (State or foreign country) DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> FORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Jan. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Butcher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 9108 2nd Ave		14 FATHER'S NAME First Benjamin Middle P. Last Lee		15. MOTHER'S M.A.DEN NAME First Eugenia Middle Chinn Last Chinn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 577-10-7870		17 INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Ischemia DUE TO, OR AS A CONSEQUENCE OF (c) Extensive Coronary Sclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 3 days Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ① Gangrene left leg ② Generalized Severe Obstructive Atherosclerosis ③ Cerebral Sclerosis							
19a. DATE OF OPERATION 4/23/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Atherosclerosis + Obstruction Femoral Artery		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) Auto			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/22 , 19 69 , to 5/2 , 19 69 , that (I) (we) last saw the deceased alive on 5/6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Marvin L. Xolkin				DEGREE PHYS		22c. DATE SIGNED 5/2/69	
22d. PHYSICIAN'S NAME (Type) MARVIN L. XOLKIN				22e. ADDRESS 1015 Spring Street, S.E., Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/10/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR MAY 12 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07133

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07129

1. DECEASED NAME (Type or print) <i>Martin A. Leibold</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>29</i> Year <i>1969</i>			2b. HOUR <i>3:30</i> PM	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>7/25/92</i>		6. AGE in years last birthday <i>76</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Hospital</i>		12a. USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired) <i>Govt</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>Lark</i>		15. MOTHER'S MAIDEN NAME <i>Unknown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>213-48-1863</i>	
17. INFORMANT <i>Ellen Leibold</i>		18. ADDRESS <i>6409 W. Montgomery Rd Bethesda Md</i>		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. LOCATION Street or R.F.D. No. City or Town County State		21g. DATE OF INJURY <i>5/28</i> 19 <i>69</i>		21h. TIME OF INJURY <i>4:00</i> PM	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/28</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Frank Y. Jagers Jr MD</i>		22c. DATE SIGNED <i>5/29/69</i>		22d. PHYSICIAN'S NAME (Type) <i>FRANK Y. JAGGERS JR</i>	
22e. ADDRESS <i>5707 WISCONSIN AVE</i>		22f. DATE SIGNED <i>5/29/69</i>		22g. PHYSICIAN'S NAME (Type) <i>FRANK Y. JAGGERS JR</i>		22h. ADDRESS <i>5707 WISCONSIN AVE</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-2-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Blanche Judge</i>		25c. DATE <i>JUN 5 1969</i>	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *412*
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF *Respiratory Failure*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 hr

(b) *Acute Coronary Thrombosis*

2 days

(c) *Chronic Coronary Heart Disease*

2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

07134

CERTIFICATE OF DEATH

07130

1. PLACE OF DEATH 3718 Williams Lane
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b 7 1/2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3718 Williams Lane

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
d. STREET ADDRESS 3718 Williams Lane e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) HENRIETA M. LEONARD
4. DATE OF DEATH May 24 1969
5. SEX F 6. COLOR OR RACE N 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Oct-30 1883 9. AGE (In years, last birthday) 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (County & State, or foreign country) James town New York 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME HECTOR MORRISON 14. MOTHER'S MAIDEN NAME ELLEN FITZPATRICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. 219-54-9633 17. INFORMANT SON Address 3718 Williams Lane

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Heart failure DUE TO Rheumatic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) — DUE TO — (c) —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1962 to May 24, 1969, that (I) (we) last saw the deceased alive on May 24, 1969, and that death occurred at 4:30 PM, from the causes and on the date stated above.

22a. SIGNATURE Irene G. Tamagna M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED May 24-1969
22c. PHYSICIAN'S NAME (Type) IRENE G. TAMAGNA M.D. 22d. ADDRESS 7101 CONNECTICUT AVE Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 5/28/69 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM. 23d. LOCATION (City, town or county) (State) SILVER SPRING MD.

24. FUNERAL DIRECTOR'S SIGNATURE HANCOCK FUNERAL HOME WASH D.C. ADDRESS — 25a. REC'D BY REGISTRAR MAY 29 1969 25b. REGISTRAR'S SIGNATURE Blanche Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

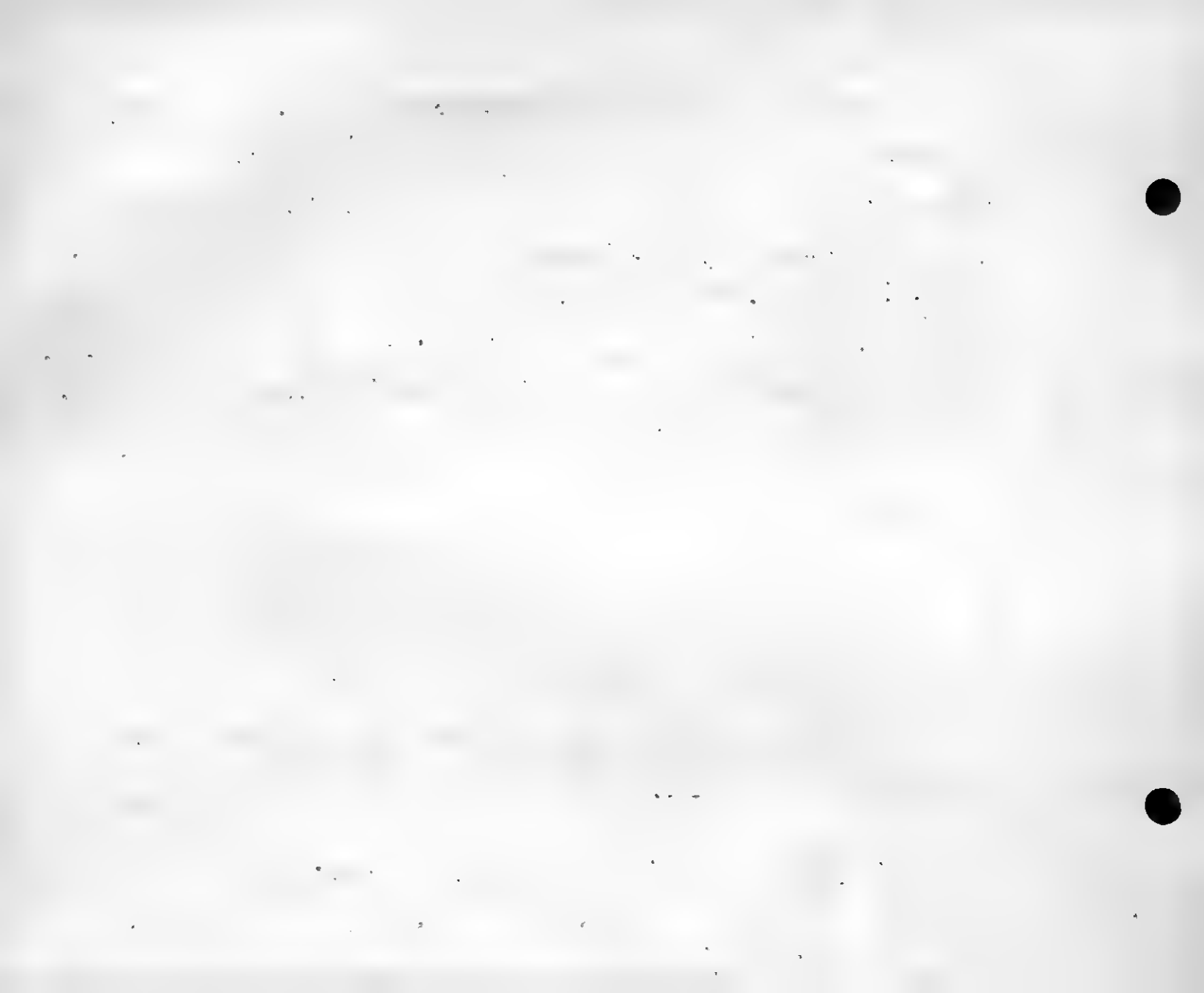
1

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07135										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07131	
Item 13 Film 0412 5/9/69 kk										CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR					
DAVID		K-		LEONHARD				5		1		1969		12		PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.											
MALE		CAUCASIAN		APR 10, 1895		74		MONTHS		DAYS		HOURS		MIN.							
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH													
ILLINOIS		U.S.A.		WIDOWED		DIVORCED		MONTGOMERY								Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY															
Silver Spring		HOLY CROSS		Retired Spec. Police		Govt.															
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. COUNTY		13c CITY OR TOWN		13a. INSIDE CITY LIMITS?		13e STREET AND NUMBER													
STATE		MONTGOMERY		Wheaton		YES		901 Arcola Avenue													
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last							
William H. Leonhard								Marie Klein													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO.		17. INFORMANT		Address															
Yes, no, or unknown		1917-19 1921-23		Rose Leonhard, Wife		20027		6402 B Street, S. E., Maryland Park, Md.													
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) ASHD																3 yrs					
4123																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
						YES		NO													
21a ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year																			
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)		21f. LOCATION		Street or R.F.D. No		City or Town		County		State									
While		OFFICE BUILDING, ETC.																			
at work																					
22a. I certify that (I) (this hospital) attended the deceased from 4/26, 1969, to 4/30, 1969, that (I) (we) last saw the deceased alive on 4/30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED											
Myron L. Lenkin										5/1/69											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS																			
MYRON L. LENKIN		2309 SHOREFIELD RD. SILVER SPRING MD																			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)											
Burial		5/5/69		Baltimore National Cemetery		Baltimore, Md.															
24 FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Robert E. Wilhelm Funeral Home		MAY 5 1969		Thomas J. Yager																	
4308 Suitland Rd., S.E., Suitland, Md., 20023																					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm and home. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 413 MARYLAND STATE DEPARTMENT OF HEALTH
6-9-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
07136 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07132

1 DECEASED NAME (Type or Print)		First Tracy		Middle Scott		Last Lewis		2a DATE KNOWN OF DEATH		Month 5-12-1969		Day 11		Year 1969		2b HOUR		11:30																																									
3 SEX	M	4 RACE	W	5 DATE OF BIRTH	10-1-68		6 AGE (In years last birthday)	7 YRS 7		8 MONTHS 7		9 DAYS 7		10 HOURS 7		11 MIN 7		2c DATE PRONOUNCED DEAD		Month 5-12-1969		Day 11		Year 1969		2d HOUR		11:30																															
7a BIRTHPLACE (State or foreign country)				W. Va.				7b CITIZEN OF WHAT COUNTRY?				US				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Montgomery Md.																																							
10 CITY OR TOWN OF DEATH				Takoma Park, Md.				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				Washington, San & Hosp				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY																																							
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE				Md.				13b COUNTY				Montgomery				13c CITY OR TOWN				Takoma Park				13d INSIDE CITY LIMITS?				YES <input type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER				7110 Poplar Ave. T.P., Md.																							
14 FATHER'S NAME				First Jerry				Middle				Last Lewis				15 MOTHER'S MAIDEN NAME				First Charlotte				Middle Ellen				Last																															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				no				16b SOCIAL SECURITY NO				17 INFORMANT				ADDRESS																																											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation due to airway obstruction																																																											
DUE TO, OR AS A CONSEQUENCE OF (b) with food (graham cracker)																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																																											
DUE TO, OR AS A CONSEQUENCE OF (c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?																																							
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY Month, Day, Year										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
										11:20 AM 5-12-69										Deceased infant aspirated particles of food																																							
21d INJURY OCCURRED										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION Street or RFD No										City or Town										County										State									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										Home										Takoma Park										Montgomery										Md.																			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																											
ACTUAL SIGNATURE										Belden R. Reap, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b DATE SIGNED																													
EXAMINER'S NAME (Type)										Belden R. Reap, M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										May 12, 1969																													
																				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																																							
																				ADDRESS (Street, city, town, or county)																																							
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town)										(County)										(State)									
Burial										May 15, 1969										Perry Alta Cemetery										Perry Alta										West Va																			
24 FUNERAL DIRECTOR										ADDRESS										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE																													
J. Arthur Walters										254 Carroll St NW Wash DC										MAY 14 1969																																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
30M REV. 7/68

07137

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07133

1 DECEASED-NAME (Type or print) ARCH			2a. DATE OF DEATH 5 Month 6 Day 69 Year			2b. HOUR 10:35 M					
3. SEX MULE		4. RACE WHITE		5. DATE OF BIRTH 6/10/196		6 AGE (In years lost birthday) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10 CITY OR TOWN OF DEATH SILVER SPRING, MD.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter			12b. KIND OF BUSINESS OR INDUSTRY Painting		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 107E MELBOURNE AVE.	
14 FATHER'S NAME First Middle Last WINIFREE			15. MOTHER'S M.A.D.E.N. NAME First Middle Last UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) Yes (If in give war or dates of service) 2/13/15 - 2/12/22			16b. SOCIAL SECURITY NO. 577-16-1598			17 INFORMANT Address Silver Spring, Md. MARY M. Lyle - 107E. MELBOURNE AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pickable Pulmonary Embolism 16d1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of Lung, Left DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 3yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from April , 1967, to 5/16 , 1967, that (I) (we) last saw the deceased alive on 5/16 , 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. Leonard Gold DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/16/69			
22d. PHYSICIAN'S NAME (Type) G. Leonard Gold						22e. ADDRESS 9801 Georgia Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 9, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Maryland				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., 8434 Georgia Avenue						25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE G. Leonard Gold			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
45M - 115

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07138					07134					
1 DECEASED NAME (Type or print) <i>Catherine B. Magee</i>					2a DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1969</i>					2b HOUR <i>1:24 AM</i>
3 SEX <i>Female</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>9/9/04</i>	6 AGE (In years last birthday) <i>64</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) <i>TEXAS</i>		7b. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md				
10 CITY OR TOWN OF DEATH <i>Beaumont</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>RESEARCHER - RETIRED</i>		12b KIND OF BUSINESS OR INDUSTRY <i>U.S. GOV'T.</i>				
13a USUAL RESIDENCE (Where deceased lived, if not at an address before admission) STATE <i>MD</i> COUNTY <i>WASHINGTON</i>		13c CITY OR TOWN <i>2</i>		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>651 Totopatch Ave. 1 L</i>				
14. FATHER'S NAME First <i>F.</i> Middle <i>B.</i> Last <i>BYNUM</i>			15 MOTHER'S MAIDEN NAME First <i>KITTY</i> Middle <i>CHAPFIELD</i> Last <i>CHAPFIELD</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>426-07-9206</i>		17 INFORMANT <i>O.H. BYNUM, BROTHER, DALLAS, TEXAS</i>		Address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Cortical Atrophy</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 months</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fibrous Myocardial Septum</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <i>July 2, 1969</i> to <i>May 3, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 2, 1969</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE <i>Michel M. Healy MD</i>		22c DATE SIGNED <i>5/3/69</i>		22d PHYSICIAN'S NAME (Type) <i>Michel M. Healy, MD</i>		22e ADDRESS <i>5411 Cedar Lane, Bethesda, Maryland</i>				
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b DATE <i>5-5-1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Prince Georges Co. MD</i>				
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, 11 ADDRESS 5130 WISC. AVE. N. W. WASH. D. C. 20016</i>				25a. REC'D BY REGISTRAR <i>MAY 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07139

CERTIFICATE OF DEATH

07135

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR P	
Harry Milton Magruder						Month	Day	Year	3:09 PM	
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		Negro		22 August 1894		74 YRS.		MONTHS	DAYS	HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Washington, D.C.		USA				Montgomery Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		The Clinical Center, NIH								
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) - STATE				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
District of Columbia				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		511 L Street, N.W.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle
James						Eva				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
			578-14-4114		The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										48 hours
IMMEDIATE CAUSE (a) Gram negative sepsis										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) Urinary tract infection										months
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
Acute leukemia										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 7 May, 1969, to 14 May, 1969, that (X) (we) last saw the deceased alive on 14 May, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Robert C. Gallagher, M.D.							14 May 1969			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Robert E. Gallagher, M.D.					The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		5-19-1969		Harmony Memorial Park		Landover, Maryland				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wash. D.C. ADDRESS MAYAN & SCHEY, INC. 424 R St., N. W.					DATE MAY 19 1969		R. E. Gallagher			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

Cleared thru Dr. John G. Ball, Dept. Med. Exam., Montg. Co., Md.

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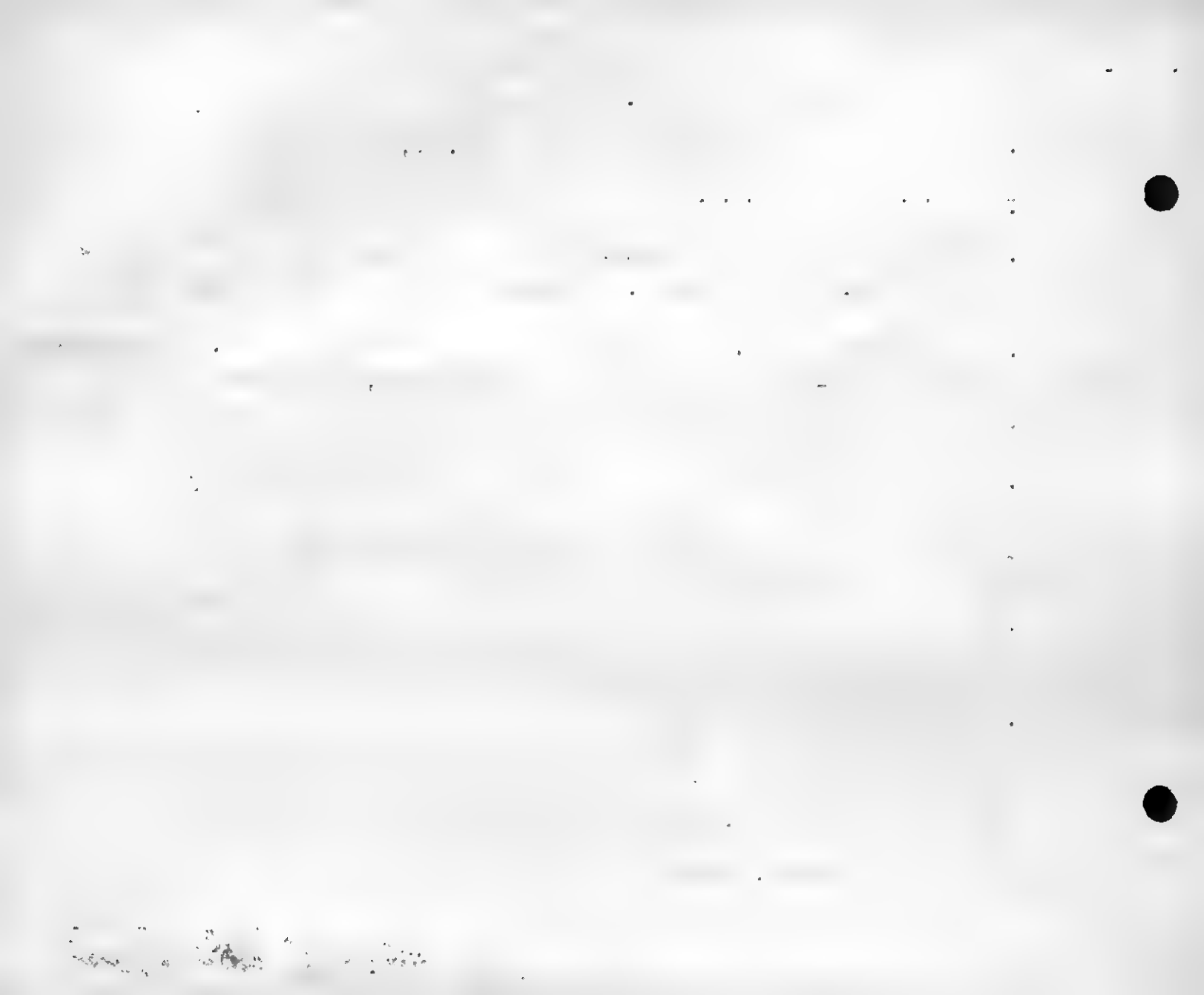
07140

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07136

1 DECEASED-NAME (Type or print) DANIEL		First B.	Middle MAHER	Last	2a DATE OF DEATH Month MAY Day 23 Year 1969	2b HOUR 11:30 AM
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH Jan. 20, 1906		6. AGE (In years) 63 (In days)	IF UNDER 1 YEAR MONTHS 1 DAYS 15	IF UNDER 24 HRS HOURS 11 MIN 30
7a. BIRTHPLACE (State or foreign country) N.J.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5405 Lambeth Road	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Attorney		12b KIND OF BUSINESS OR INDUSTRY Law		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b COUNTY Montg.	13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5405 Lambeth Road		
14 FATHER'S NAME First Edward Middle F. Last Maher	5 MOTHER'S MAIDEN NAME First Martha Middle E. Last Cunningham					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No	16b SOCIAL SECURITY NO	17 INFORMANT Helen W Maher, Same as #13				
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Arteriosclerosis HD DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs + 15 yrs +						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus 10 yrs +						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 5/21/69 , to 5/23/69 , that (I) (we) last saw the deceased alive on 5/21/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Thomas F. Keliher MD	DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/23/69			
22d PHYSICIAN'S NAME (Type) Thomas F. Keliher	22e ADDRESS 3800 Reservoir Rd. Wash. DC.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE 5/27/69	23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEM.	23d LOCATION (City or Town) (County) (State) ROCKVILLE, MD.			
24. FUNERAL DIRECTOR JOSE GAWLERISSONS	ADDRESS 5130 WISCONSIN AVE. WASHINGTON, D.C.	25a REC'D BY REGISTRAR MAY 28 1969	25b REGISTRAR'S SIGNATURE Charles J. Suggs			



1830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07141										
07137										
1. DECEASED-NAME (Type or print)		First EVALIN		Middle NMN		Last MALONY		2a. DATE OF DEATH Month 5 Day 31 Year 69		2b. HOUR 7:50A
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-29-20		6. AGE (In years, lost birthday) 48 YRS.		7. UNKOR 1 YEAR MONTHS DAYS		8. UNKOR 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PSYCHIATRIC SUPT.		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD #2, Box 202		
14. FATHER'S NAME First HAROLD		Middle MITCHELL		Last MITCHELL		15. MOTHER'S MAIDEN NAME First MARY		Middle HOLLIDAY		Last HOLLIDAY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 118-18-9425		17. INFORMANT Mary H. Mitchell		Address Same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Emboli DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF (c) Ovarian Cancer PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Days Months
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Apr 10 , 19 69 , to May 31 , 19 69 , that (I) (we) saw the deceased alive on May 31 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death										
22b. SIGNATURE STEVEN CONWAY MD		22c. DATE SIGNED 5/31/69		22d. PHYSICIAN'S NAME (Type) STEVEN CONWAY MD		22e. ADDRESS 57010 FREDERICK		22f. ATTENDING <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 2 1969		23c. NAME OF CEMETERY OR CREMATORY Donation to George Wash. Medical school		23d. LOCATION (City or Town) (County) (State) Wash. D.C.				
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Home Laytonsville		25a. REC'D BY REGISTRAR JUN 5 1969		25b. REGISTRAR'S SIGNATURE Richard Judge				



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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07142

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07138

1 DECEASED-NAME (Type or Print) SARA		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> May 21 19 69		2b HOUR 1:45 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 2/15/91		6 AGE (in years last birthday) 78 YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____	
7a BIRTHPLACE (State or foreign country) Georgia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery				Md.	
10 CITY OR TOWN OF DEATH Silver Spring				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY -----	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b COUNTY Montgom.		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6121 Montrose Ave.	
14 FATHER'S NAME Abraham				First		Middle		Last		15. MOTHER'S MAIDEN NAME Jennie	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO unknown		17. INFORMANT Janette Getz, 10500 Rockville Pike, Rockville				ADDRESS MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure 4123 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. _____ 19 _____		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____		City or Town _____		County _____		State _____	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED May 21, 1969		ADDRESS (City or Town or County)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5-22-69		23c NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d LOCATION (City or Town) (County) (State) Atlanta, Ga.					
24 FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th Street N.W.				ADDRESS		25a REC'D BY REGISTRAR DATE MAY 26 1969		25b REGISTRAR'S SIGNATURE William S. Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

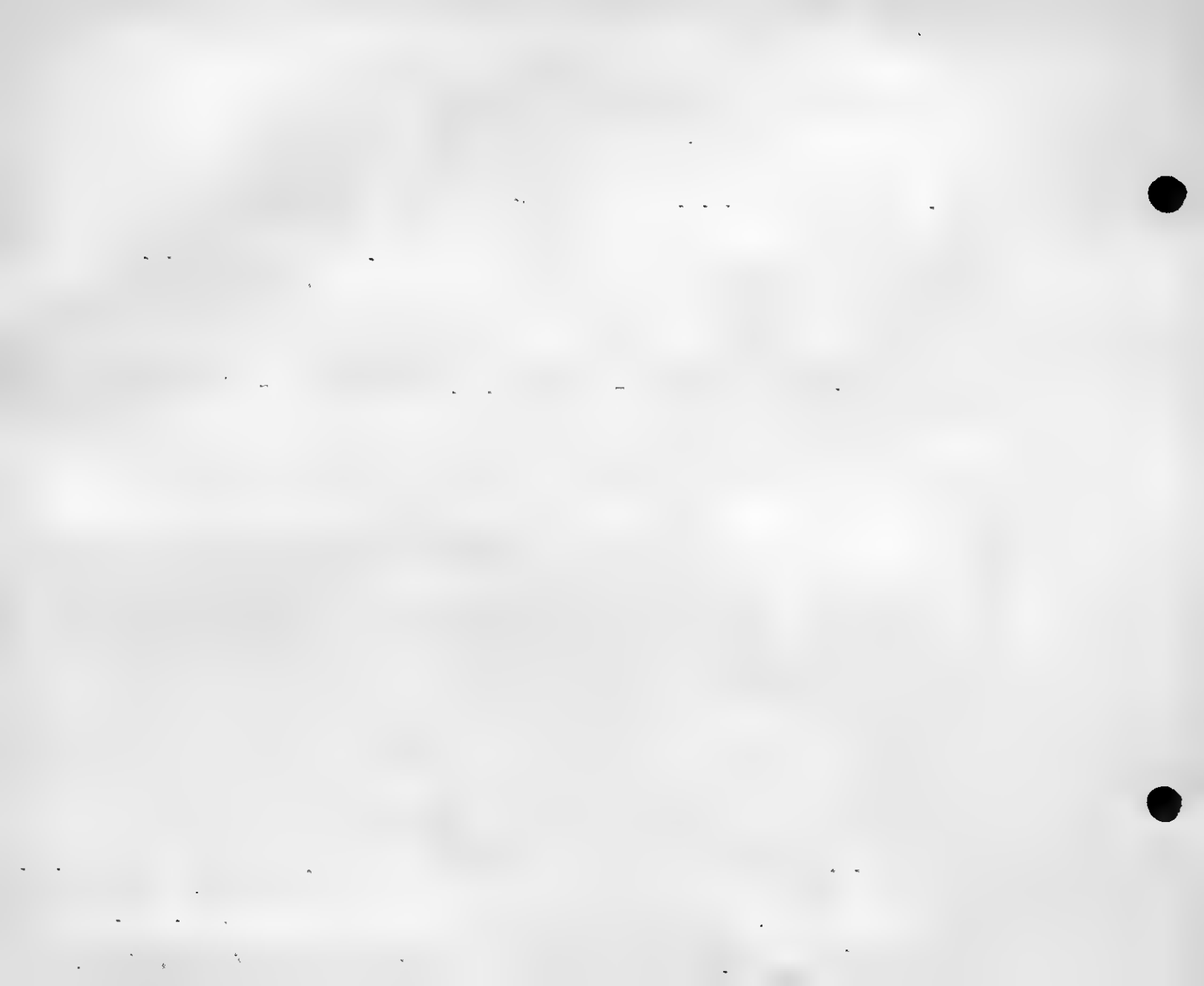
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07143

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07139

1. DECEASED-NAME (Type or print) Frank Belmont Marks			2a. DATE OF DEATH Month 5 Day 15 Year 69			2b. HOUR 3 P. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 16, 1882		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Balto., Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 617 Bennington Lane		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Pound Master D.C. Government		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USJA. RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY L.M.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 617 Bennington Lane	
14. FATHER'S NAME First Middle Last unk			15. MOTHER'S M.A.DEN NAME First Middle Last unk			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO 216-46-20139		17. INFORMANT Daughter			Address: Silver Spring, Md 617 Bennington Lane				
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pressure 4 Asphyxial Asphyxia DUE TO, OR AS A CONSEQUENCE OF (b) Asphyxial Asphyxia DUE TO, OR AS A CONSEQUENCE OF (c) Proxic Myocarditis Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 14 days 10 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (his hospital) attended the deceased from 19 , 19 52 , to 3/18 , 19 69 , that (I) (we) last saw the deceased alive on 3/19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (and) view the body after death									
22b. SIGNATURE A.C. Leonardo				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/15/69			
22d. PHYSICIAN'S NAME (Type) A.C. Leonardo				22e. ADDRESS 5801 13th St., N.W., Washington, D. C.					
23a. BURIAL, CREMATION, REMOVA (Specify) Burial		23b. DATE May 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Pr. Geo. Maryland			
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc., Silver Spring, Maryland				25a. REC'D BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07144

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07140

1 DECEASED-NAME (Type or print) First <u>Jacob</u> Middle <u>Martin</u> Last <u>Jacob Martin</u>		2a DATE OF DEATH Month <u>5</u> - Day <u>4</u> - Year <u>69</u>		2b HOUR <u>9:30 P</u>	
3 SEX <u>Male</u>		4 RACE <u>Negro</u>		5. DATE OF BIRTH <u>12-9-89</u>	
7a BIRTHPLACE (State or foreign country) <u>Md.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Montgomery.</u>		10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>md</u>	
13b COUNTY <u>Montg.</u>		13c CITY OR TOWN <u>Rockville</u>		13d YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <u>1250 1st Street</u>		14. FATHER'S NAME First <u>Winfield</u> Middle <u>Martin</u> Last <u>Martin</u>		15. MOTHER'S MAIDEN NAME First <u>Jennie</u> Middle <u></u> Last <u></u>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u>		16b SOCIAL SECURITY NO <u></u>		17. INFORMANT <u>Carrie Martin</u> Address <u>1250 1st Street</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Intracerebellar hemorrhage, right, spontaneous</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive heart disease</u> Approximate interval between onset and death <u>3 days</u> <u>years</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <u>Hypostatic broncho-pneumonia.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 29</u> , 19 <u>67</u> , to <u>May 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 4</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>John S. Sauer</u>		22c DEGREE <u>MD</u>		22d ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22e ADDRESS <u></u>		22f DATE SIGNED <u>5-5-69</u>		22g	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>5/10/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cem.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Quince Orchard Md.</u>		23e REC'D BY REGISTRAR <u>May 8 1969</u>		23f REGISTRAR'S SIGNATURE <u>Lois R. Snowden</u>	
24. FUNERAL DIRECTOR <u>Lois R. Snowden</u>		24b ADDRESS <u>Rockville</u>		24c	

VR 45M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

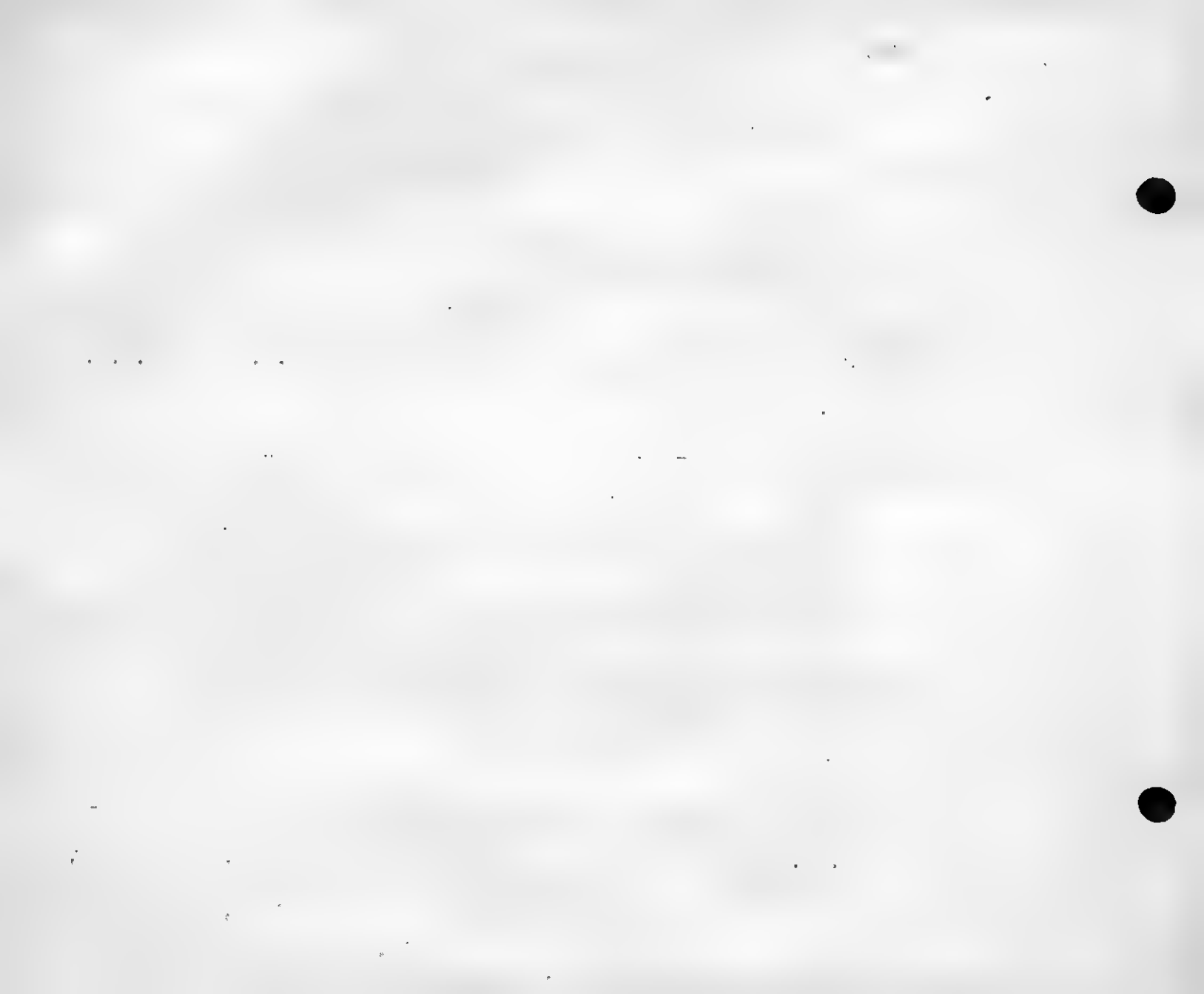
07145

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07141

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 601 Anderson Avenue		d. STREET ADDRESS 601 Anderson Avenue	
3 NAME OF DECEASED (Type or print) Raymond LeRoy Martin		4 DATE OF DEATH Month May Day 18 Year 1969	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 14, 1895
9 AGE (In years) 74 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Henry C. Martin		14. MOTHER'S MAIDEN NAME Olive Makely	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16 SOCIAL SECURITY NO. 216-46-1267-M	
17. INFORMANT Lillian May Martin - Wife		Address Maryland Box 107 Olney	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Carcinoma of mouth + tongue DUE TO (c) Emphysema		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 3 yrs 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 1961 , 19 to 5-18, 1969 , that (I) (we) last saw the deceased alive on 5-18, 1969 , and that death occurred at 10:00 P.M. from causes on and on the date stated above.			
22a. SIGNATURE W. G. Hall		22b. DATE SIGNED 5-19-69	
22c. PHYSICIAN'S NAME (Type) W. G. Hall		22d. ADDRESS 615 Montgomery Ave., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/69	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR May 21 1969	
ADDRESS Rockville, Maryland		25b. REGISTRAR'S SIGNATURE Richard J. Jordan	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VERA 1-1-61
304 REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07146

CERTIFICATE OF DEATH

07142

1. DECEASED NAME (Type or print) Susie Mary Martin			2a. DATE OF DEATH Month 5 Day 21 Year 69			2b. HOUR 6:30 A.M.							
3. SEX FEMALE		4. RACE Negro		5. DATE OF BIRTH Dec. 10, 1896		6. AGE (In years last birthday) 72 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md.				
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) 331 Lincoln Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.			13b. CITY OR TOWN Montg. Rockville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 331 Lincoln Ave.						
14. FATHER'S NAME First RICHARD Middle HEBRON Last Susie			15. MOTHER'S MAIDEN NAME First Driver Middle Susie Last Driver										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Pyelonephritis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4-10-1963 to 5-21-1969 , that (I) (we) last saw the deceased alive on 4-10-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE D. L. Bucy / S. Jones			DEGREE D.L. Bucy / S. Jones			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 5-21-69				
22d. PHYSICIAN'S NAME (Type) D.L. Bucy / S. Jones			22e. ADDRESS 809 Views Mill Rd Rockville Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 5/24/69			23c. NAME OF CEMETERY OR CREMATORY ST Paul Cemetery			23d. LOCATION (City or Town) (County) (State) Sugarland Montg. Md.				
24. FUNERAL DIRECTOR Robert L. Snowden			ADDRESS Rockville, Md.			25a. RECD BY REGISTRAR DATE MAY 23 1969			25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

Dr. Ball Notified & approved

MEDICAL CERTIFICATE ON

1 DECEASED NAME										2a DATE OF DEATH		2b HOUR		
First			Middle			Last			Month		Day		Year	
ANN			GERTRUDE			MARTINEZ			MAY		31		1969	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		CAUCASIAN		27 DEC 1904			64 YRS		MONTHS		DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
WASHINGTON, DC			U.S.A.					MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY		
BETHESDA				NAVAL HOSPITAL				HOUSEWIFE						
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER				
MD				PRINCE GEORGES		LANHAN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9603 WELLINGTON ST				
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME										
JAMES G				BERRY										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT Address								
NO				579-24-5610		VIRGIN M HUMPHRIES 9603 WELLINGTON ST LANHAN, MD								
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION														
4109 DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC- CARDIOVASCULAR DISEASE														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
CARCINOMA OF THE CERVIX, STAGE IV														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			HOUR A.M. Month Day Year P.M. 19											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (this hospital) attended the deceased from 30 MAY, 19 69, to 31 MAY, 19 69, that (we) lost saw the deceased alive on 31 MAY, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED				
D. L. HORTON M.D.										1 JUN 69				
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS								
						NAVAL HOSPITAL, BETHESDA, MD								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL			6/4/69		ARLINGTON NATIONAL				ARLINGTON, VIRGINIA					
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE						
GASCH FUNERAL HOME HYATTSVILLE, MD						JUN 5 1969		[Signature]						

4101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1516
30M REV 1-68

07148

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07144

1. DECEASED-NAME (Type or print) Austin E Mayn			2a. DATE OF DEATH Month May Day 17 Year 1969			2b. HOUR 7:41 PM	
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH 7/28/19		6. AGE (In years last birthday) 49 YRS.	
7a. BIRTHPLACE (State or foreign country) DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp of SS.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Pot Elec Pow Co	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spri		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4305 Ferrara Dr		14. FATHER'S NAME First Charles Middle Mayn Last Ammon		15. MOTHER'S MAIDEN NAME First Ammon Middle Snoots Last Snoots			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) Yes (If yes give year or dates of service) WW II		16b. SOCIAL SECURITY NO 577-20-2759		17. INFORMANT Ann M. Mayn - 1354 Univ. Blvd., E., Hyattsville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Anteromedial Heart Disease Gross. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-12 , 19 69 , to 5-17 , 19 69 , that (I) (we) last saw the deceased alive on 5-17-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Morris Perry		22c. DATE SIGNED 5-17-69		22d. PHYSICIAN'S NAME (Type) Morris Perry		22e. ADDRESS 11602 Georgia Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR C. Gle. Pumphrey, Inc.		25a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc.		25b. REGISTRAR'S SIGNATURE Charles J. J...		DATE MAY 22 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07149

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07145

1. DECEASED-NAME (Type or print) Julia Elizabeth Me Carty			2a. DATE OF DEATH Month May Day 11 Year 1969			2b. HOUR 5 36 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 8, 1892		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Ashton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) —			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Res. dence before admission) STATE Md			13b. COUNTY Montgomery		13c. CITY OR TOWN Ashton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Othneil Middle Hart Last Larivill			15. MOTHER'S MAIDEN NAME First Bessie Middle White Last White							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 577 42 6070		17. INFORMANT W. S. Thomas			Address 1603 Revere Drive Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic Bronchitis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wk YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 53 , to 4/11 , 19 69 , that (I) (we) lost saw the deceased alive on 4/11 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE C. H. Ligon			22c. PHYSICIAN'S NAME (Type) C. H. Ligon			22d. ADDRESS Sandy Spring Md.		22e. DATE SIGNED 5/14/69		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE May 14 1969			23c. NAME OF CEMETERY OR CREMATORY Lake View			23d. LOCATION (City or Town) (County) (State) Hamilton Virginia	
24. FUNERAL DIRECTOR Francis H. Barber			ADDRESS Laytonsville Md			25a. REC'D BY REGISTRAR MAY 16 1969		25b. REGISTRAR'S SIGNATURE <i>Francis H. Barber</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07150		CERTIFICATE OF DEATH				07146			
1 DECEASED NAME (Type or print) William			First Howard Middle McCauley Last			2a. DATE OF DEATH Month 5 Day 19 Year 69			2b. HOUR 9:15 P.M.
3 SEX MALE		4. RACE White		5. DATE OF BIRTH 1/26/07		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 15 HOURS 15 MIN	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ass't treasurer - Nat'l Geograph Soc.			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1401 Crestridge Dr			14 FATHER'S NAME First Samuel Middle H. Last McCauley			15 MOTHER'S MAIDEN NAME First Nina Middle Barrett Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 424			17 INFORMANT Elizabeth McCauley-1401 Crestridge Dr., S.S. Md.			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal fibrosarcoma 1950 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from 7-15, 1965 , to 5-18, 1969 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 5-18, 1969 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE G. G. Sengstack M.D.					22c. DATE SIGNED 5-19-69		22d. PHYSICIAN'S NAME (Type) G. G. Sengstack		
22e. ADDRESS 9241 Columbia Blvd., Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Maryland			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., 8434 Georgia Avenue					RECORDED BY REGISTRAR MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07151

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07147

1. DECEASED-NAME (Type or print) <i>Maude</i> First <i>B</i> Middle <i>M</i> Last <i>McGinnick</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>23</i> Year <i>1969</i>			2b. HOUR <i>5⁴⁵ P. M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 12, 1880</i>		6. AGE (In years lost birthday) <i>88</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Michigan</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Wheat, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brooke Grove Foundation</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>6106 Bradley Blvd</i>		14. FATHER'S NAME First <i>James</i> Middle <i>A</i> Last <i>Beerman</i>		15. MOTHER'S MAIDEN NAME First <i>Eliza</i> Middle <i>Knight</i> Last <i>Knight</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>523-32-9648</i>		17. INFORMANT <i>NURSING HOME RECORDS -</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4124 Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lost.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>June, 1967</i> to <i>May 25, 1969</i> , that (I) (we) lost saw the deceased alive on <i>May 25, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Frederick Mooman, MD</i>				22c. ADDRESS <i>Medical Center, Sandy Spring, Md.</i>		22d. DATE SIGNED <i>May 25, 1969</i>	
22e. PHYSICIAN'S NAME (Type) <i>Frederick Mooman</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>5-26-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington University Medical School-Anatomical</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON</i>				25a. REC'D BY REGISTRAR <i>MAY 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07152

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07148

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <i>Antoinette McCallough</i>		2a. DATE OF DEATH Month Day Year <i>May 4 1969</i>		2b. HOUR AM PM <i>9:45</i>
3 SEX <i>female</i>	4. RACE <i>white</i>	5 DATE OF BIRTH <i>6/9/24</i>	6. AGE (in years last birthday) <i>44</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS
7a BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Medical Center</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>Md.</i>	13b. CITY OR TOWN <i>Montgomery</i>	13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>435-5198 Ave.</i>	
14. FATHER'S NAME First Middle Last <i>Milton Padagas</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>Eudokia Kelle's</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <i>no</i>	16b SOCIAL SECURITY NO. <i>577-26-6123</i>	17. INFORMANT Address <i>Lawrence McCallough, Jr. 1500</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal varices, ruptured</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis, Laennec's</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> , 19 <u>69</u> , to <u>5/1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Frederick Y. Down</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>5/1/1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>Frederick Y. Down</i>		22e. ADDRESS <i>10950 Conn. Ave. Kensington, Md</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May 5, 1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>Glen Carter Warner E. Pumphrey, Inc.</i>		ADDRESS <i>Silver Spring, Maryland 8434 Georgia Avenue</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 7 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07153

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07149

1 DECEASED NAME (Type or Print) Steven First Thomas Middle McBee Last			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5 17 1969			2b HOUR OF DEATH 10 05 PM							
3 SEX M.		4 RACE W.		5 DATE OF BIRTH May 26, 1954		6 AGE (in years last birthday) 14 yrs		7c DATE PRONOUNCED DEAD Month May Day 17 Year 1969		2d HOUR 10 PM			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Derwood				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 5924 Moncaster Mill Rd				12a USJA. OCCUPATION (Kind of work done during most of work life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution) STATE Md. COUNTY Montgomery				13c CITY OR TOWN Derwood				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET AND NUMBER 5924 Moncaster mill rd.	
14 FATHER'S NAME Carl W. First McBee Middle McBee Last				15 MOTHER'S MAIDEN NAME Joanne First Doucette Middle Doucette Last									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO				17 INFORMANT ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun Shot Wound of Head -												Sudden	
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year 10 05 PM 5/17 1969				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) When playing with guns with boy friend shot accidentally					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f LOCATION Street or RFD No City or Town County State 5924 Moncaster Mill Rd Derwood Montgomery Md.					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED May 18, 1969					
EXAMINER'S NAME (Type) John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
				ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL, (Specify) Burial				23b DATE May 21 1969				23c NAME OF CEMETERY OR CREMATORY Laytonsville					
				23d LOCATION (City or Town) (County) (State) Laytonsville Mont. Md.									
24 FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville Md.				25a REC'D BY REGISTRAR MAY 22 1969					
								25b REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M 5-27-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Paul T. McHenry			First Middle Last Paul T. McHenry McHenry			2a. DATE OF DEATH Month Day Year May 22 1969		2b. HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Sept 11, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Bethesda, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Realtor		12b. KIND OF BUSINESS OR INDUSTRY Real Estate			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.		13b. CITY OR TOWN Berkley Springs		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 208 Wilkes S Berkley Springs, W. Va.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO 217-24-8304		17. INFORMANT Berkley, Springs, W. Va. Mrs. Evelyn McHenry, 208 Wilkes St.				
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD & 2 prior myocardial infarctions</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 yrs.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-8-69</u> , 19 <u>69</u> , to <u>5-22</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>May 14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>Frederick Mooman MD</u>				22c. DATE SIGNED 5-23-69		22d. PHYSICIAN'S NAME (Type) Frederick Mooman			
22e. ADDRESS Suburban Hospital, Bethesda, Md.									
23a. B. RIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/26/69		23c. NAME OF CEMETERY OR CREMATORY Linden-Linthicum		23d. LOCATION (City or Town) (County) (State) Clarksville, Maryland			
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry Witzke				ADDRESS Ellicott City Maryland		25a. REC'D BY REGISTRAR MAY 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07151

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G412 5/12/69 kk

CERTIFICATE OF DEATH

07151

1 DECEASED NAME (Type or print) First Middle Last Rita Doreen MC NABB			2a DATE OF DEATH Month Day Year May 3 1969		2b HOUR 1145 M
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH Jul. 3, 1931		6 AGE (In years last birthday) 37 37 YRS	7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Canada	7b CITIZEN OF WHAT COUNTRY? Canada	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b KIND OF BUSINESS OR INDUSTRY Shoe House		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b COUNTY Montgomery	13. CITY OR TOWN Wheaton	3a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 10815 Bucknell Drive	
14. FATHER'S NAME First Middle Last Roy Douglas Rodgers	15 MOTHER'S MAIDEN NAME First Middle Last Mabel E. Troy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> NO	16b SOCIAL SECURITY NO. None	17 INFORMANT Wheaton Address Md. 11 Sgt. Lawrence G. McNabb, 10815 Bucknell Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant Mellanoma</u> <u>1727</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home farm, street, factory) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (1) (this hospital) attended the deceased from <u>April 23, 1969</u> , to <u>May 3, 1969</u> , that (2) (we) last saw the deceased alive on <u>May 3, 1969</u> , and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <u>D. L. Horton, MD</u>	DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 6 May 1969			
22d. PHYSICIAN'S NAME (Type) D. L. HORTON, LT MC USNR	22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE May 8, 1969	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery, Md.		
24. FUNERAL HOME H. E. Pumphrey Funeral Home 8434 Georgia Ave., Silver Spring, Md.		25a. REC'D BY REGISTRAR MAY 8 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 1/69

07152

1 DECEASED NAME (Type or print) MARY		First Middle Last PHILOMENA MEAGHER		2a DATE OF DEATH Month 5 Day 28 Year 69		2b HOUR 1:15 M	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH 8/27/1897		6 AGE (In years last birthday) 71 YRS	
7a BIRTHPLACE (State or foreign country) Phila., Pa.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Wheaton, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nurs. Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Filing systems clerk		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission), STATE District of Columbia		13b COUNTY Wash		13c INS DE CITY, M 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1735. New Hampshire ave	
14 FATHER'S NAME First Middle Last John m m Meagher				15 MOTHER'S MAIDEN NAME First Middle Last Catherin Kelleher			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) no		16b SOCIAL SECURITY NO (If yes give war or dates of service) 186-05-4411		17 INFORMANT Address Catherine Crawford.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1969, to 5/18, 1969, that (I) (we) saw the deceased alive on 5/18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE W. Tabb Moore				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 5/26/69	
22d PHYSICIAN'S NAME (Type) Tabb Moore, M.D.				22e ADDRESS 2001 I St., NJ, Washington, DC			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 5.28.69		23c NAME OF CEMETERY OR CREMATORY Whitemarsh Memo. Park		23d LOCATION (City or Town) (County) (State) Prospectville. Penna	
24 FUNERAL DIRECTOR The Funeral Home 3004 4th St Wash DC				25a REC'D BY REGISTRAR DATE MAY 28. 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1 & 2. a Film 414
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07153

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOJR
Rose Marie Middleton					MAY 5- 15 1969					2:48 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years and months)	7 UNDER YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year
F	W	8-4-03	65 YRS	MONTHS	DAYS	MAY 5- 15 1969				1969
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Ext. Maryland - U.S.A.		U.S.A.				Montgomery		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park		Wash. San & Hosp								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Montgomery		T. Park		YES <input type="checkbox"/> NO <input type="checkbox"/>		8221 Flower Ave.		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
Jacob Bonheur				Bonner	Sarah				Gottlieb	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		
				518-36-1891		James T. Middleton (son)		414 + York Road Ave. New York City N.Y.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____										
485 X Acute bronchopneumonia associated										
DUE TO, OR AS A CONSEQUENCE OF _____										
with arteriosclerotic heart disease.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF _____										
(c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. 19 P.M.								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				
Belden R. Reap M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				May 15, 1969				
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town, County)				
BELDEN R. REAP M.D.		414 York Road Ave. New York City N.Y.								
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Cremation		May 19, 1969		Ford Lincoln Cemetery		Calmar Manor				Md.
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Arthur Wallers		254 Carroll BLVD WDC				MAY 19 1969		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07158

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07154

1 DECEASED-NAME (Type or print) First Middle Last George P. Miller			2a DATE OF DEATH Month Day Year 5 3 69			2b HOUR M					
3 SEX M		4 RACE W		5. DATE OF BIRTH 7-10-02		6 AGE (In years lost birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Mass.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montg. County Md.					
10. CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Consultant-Engineer			12b KIND OF BUSINESS OR INDUSTRY G.S.A.		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c CITY OR TOWN Zulter		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Reservoir Road, Zulter, Md.		
14. FATHER'S NAME First Middle Last George P. Miller			15. MOTHER'S MAIDEN NAME First Middle Last Bertha Jack								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 339-09-8322-A		17. INFORMANT Address Md. Mrs. Jeanne Miller, Reservoir Road, Zulter.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Anaplastic Alveolar Cell Adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 69, to 3 MAY 19 69, that (I) (we) last saw the deceased alive on 3 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard Compton MD						DEGREE PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4 May 69		
22d. PHYSICIAN'S NAME (Type) J. RICHARD COMPTON						22e. ADDRESS 612 MAIN ST. LAUREL MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE May 6, 1969			23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville, Mont., Maryland		
24. FUNERAL DIRECTOR Paul Smith, 4434 Georgia Avenue Silver Spring, Md.						25a. REC'D BY REGISTRAR DATE MAY 7 1969			25b. REGISTRAR'S SIGNATURE William J. Jones		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07159

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07155

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GLADYS L. MILLER			2a. DATE OF DEATH Month May Day 28 Year 1969		2b. HOUR 12:45 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH 8/11/96		6. AGE (in years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Royal Typewriter Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1400 Fenwick Lane	
14. FATHER'S NAME First Middle Last William Davies			15. MOTHER'S MAIDEN NAME First Middle Last -----		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 578-26-3114	17. INFORMANT William A. Derlew-Wheaton, Md. Address 12701 Barbara Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Mitral Stenosis with Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic Heart Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months Years? Years?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SEVERE ARTERIOSCLEROSIS AND CORONARY DISEASE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1969 , to May 27, 1969 , that (I) (we) last saw the deceased alive on May 27, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hop G. Graziani MD			DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/28/69
22d. PHYSICIAN'S NAME (Type) HUBO G. GRAZIANI MD			22e. ADDRESS 10101 GEORGIA AVE. S.S. MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 5/31/69	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR THE S.H. HINES CO.			ADDRESS 2901 14th ST. NW	25a. REC'D BY REGISTRAR DAI JUN 2 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07160		CERTIFICATE OF DEATH						07156	
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Rudolph			L Miller			Month Day Year May 29 1969			12:45 AM
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
Male	White		3/16/198			71 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Iowa		USA				Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda			Suburban Hosp.			Retired		U.S. Gov.	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
D.C.					Washington			6612 Barnaby St. N.W.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Paul L Miller			Emma C Anderson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT		Address		
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> WWI			577-58-3769		Wife Esther Miller		Same as above #13		
18. CAUSE OF DEATH (Enter only one cause per type for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis (generalized)									4 months
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Stomach									1 year
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		P.M. 19							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb 19 57, to May 29 19 69, that (I) (we) last saw the deceased alive on May 29 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.									
22b SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22e ADDRESS		22c. DATE SIGNED			
[Signature]		MICHEL M. HEALY		5411 CEDAR LA., BETH., MD.		5/29/69			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		6/2/69		ROCK CREEK CEM.		WASHINGTON, D.C.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
JOS. GAWLER'S SONS		5130 WIS. AVE., WASH., D.C.		JUN 5 1969		[Signature]			

CERTIFICATE OF DEATH

07157

07161

1 DECEASED-NAME (Type or print) Altha Ewalt Moody			2a. DATE OF DEATH Month 4 Day 1969 Year			2b. HOUR 5:45 M				
3 SEX Female		4 RACE White		5. DATE OF BIRTH Sept. 7, 1881		6 AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) KANSAS		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Woodacres		13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>		13e. STREET AND NUMBER 6008 Cobalt Rd.	
14. FATHER'S NAME First Middle Last Richard Thornton Ewalt			15. MOTHER'S MAIDEN NAME First Middle Last Adeline Holten Martin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 578-62-9572		17. INFORMANT Address Mrs. Bert W. Morrow 6008 Cobalt Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatous, type undetermined 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1) Diabetes mellitus 2) arteriosclerosis 3) Uremia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from 1948 to May 4, 1969 , that (I) (we) last saw the deceased alive on May 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph J. Wallace M.D.			M.D. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED May 4, 1969				
22d. PHYSICIAN'S NAME (Type) JOSEPH J. WALLACE, M.D.			22e. ADDRESS 1302 18th St. N.W. Wash. D.C. 20036							
23a. BURIAL, CREMATION, or other disposition Buried			23b. DATE 5-6-69		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City or Town) (County) (State) Rockville Mont. Md.			
24. FUNERAL DIRECTOR Robert A. Pumphrey			ADDRESS 7557 Wisc. Beth. Md.			25a. REC'D BY REGISTRAR DATE MAY 12 1969		25b. REGISTRAR'S SIGNATURE William J. Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

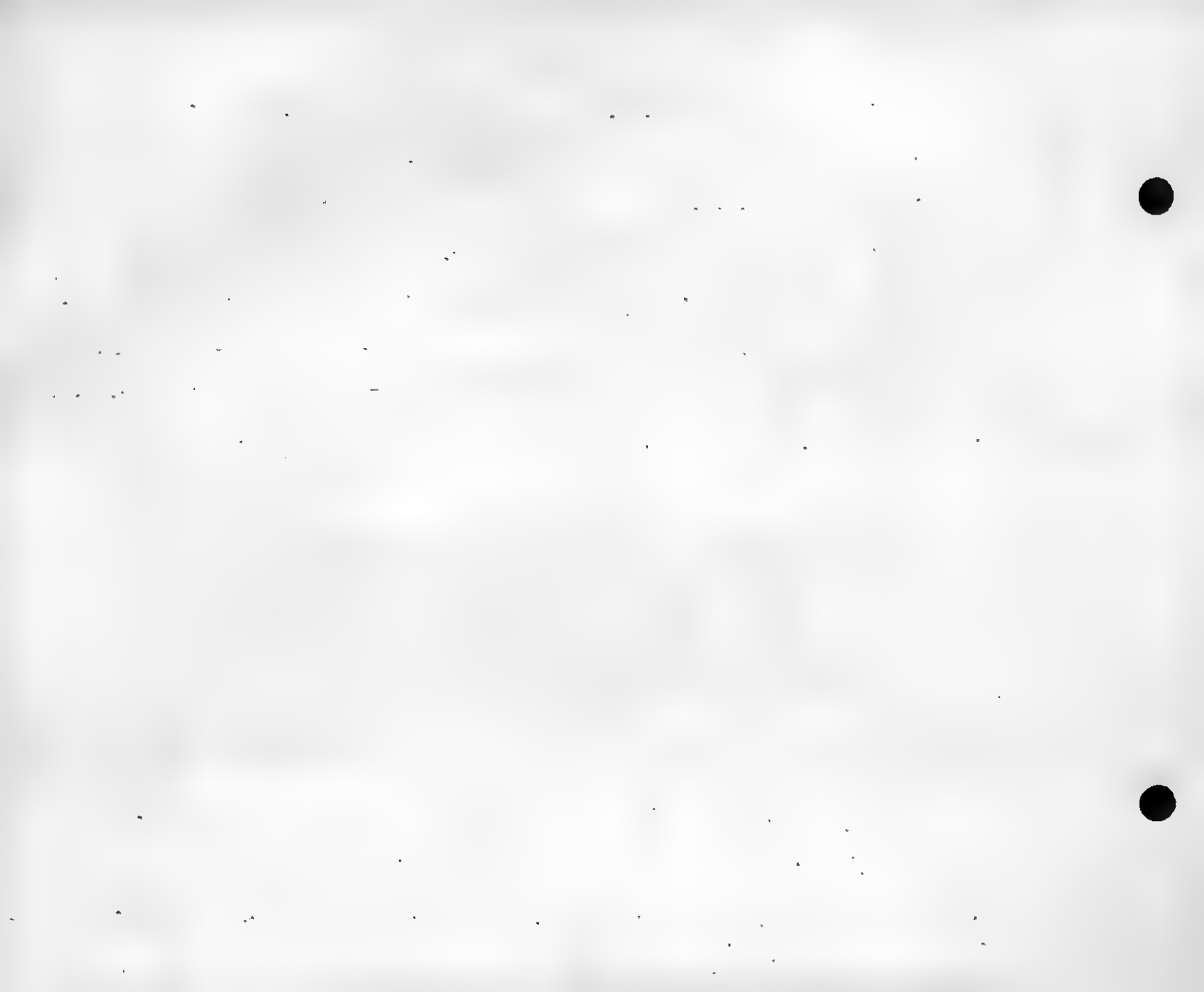
07162

07158

1. DECEASED-NAME (Type or print) Ann M. MOON			2a. DATE OF DEATH Month May Day 9 Year 1969			2b. HOUR 2:00 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 24, 1887		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 415 Silver Spring Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 415 Silver Spring Ave. #405	
14. FATHER'S NAME First Middle Last John C. Cavanaugh			15. MOTHER'S MAIDEN NAME First Middle Last Joan - Lynch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO None		17. INFORMANT Address Miss Jane Moon 415 Silver Spring Ave. S.S. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes YRS.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 67 , to 5/9 , 19 69 , that (I) (we) last saw the deceased alive on 5/8 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R.T. Benack MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 5/9/69				
22d. PHYSICIAN'S NAME (Type) R.T. Benack MD						22e. ADDRESS 4115 Colie Drive, Wheaton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE May 12, 1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery, Md.			
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc., 8434 Georgia Avenue						25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

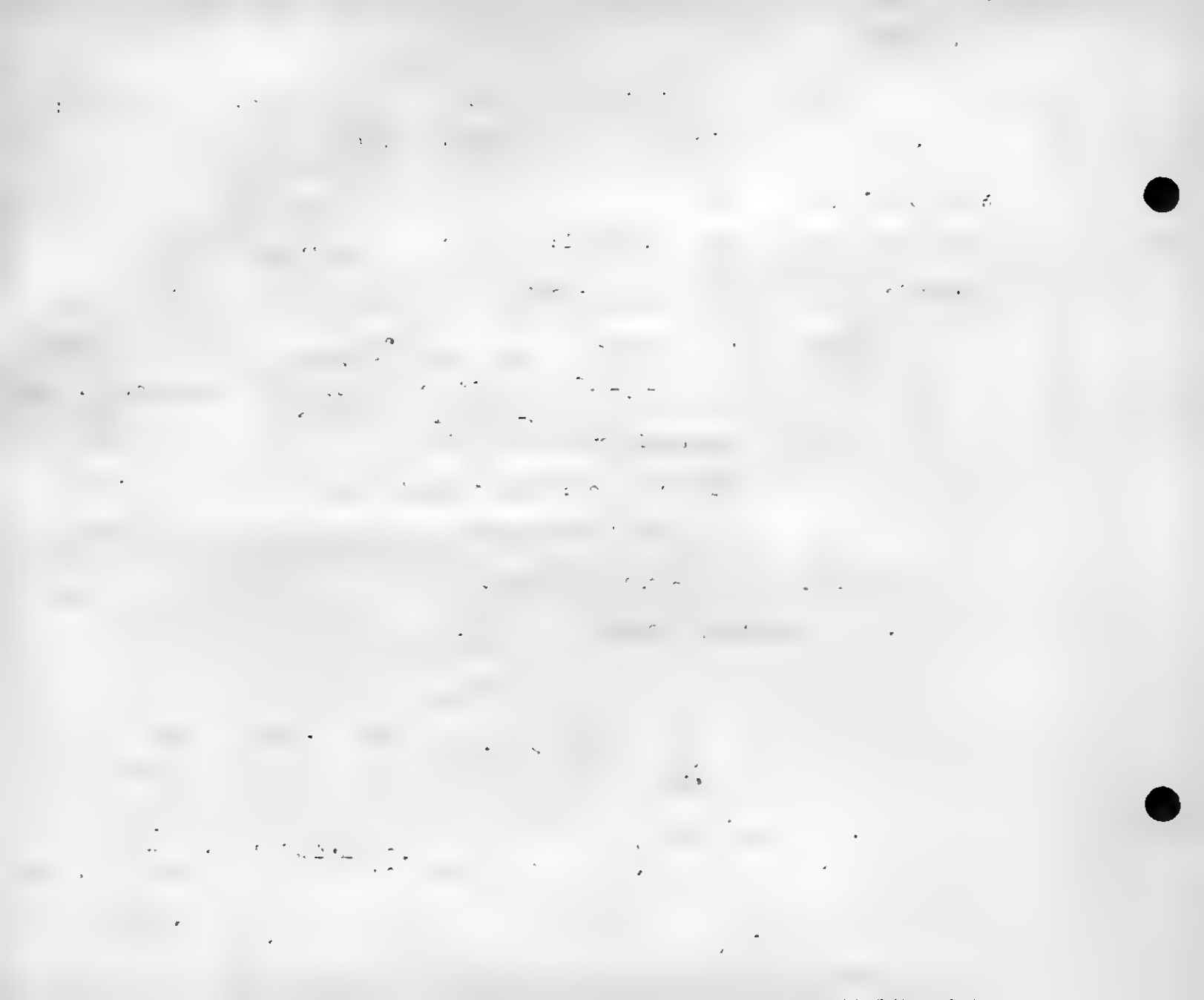
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07163		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07159	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print)		First Hughes		Middle Louis		Last Moore	
3 SEX Male		4. RACE Negro		5. DATE OF BIRTH 7 October 1916		2a. DATE OF DEATH Month May Day 3 Year 1969	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Connecticut		13b. COUNTY Stamford		13c. CITY OR TOWN Stamford		13d. INSIDE CITY - HTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 94 Henry Street		14. FATHER'S NAME First Andrew Middle T. Last Moore		15. MOTHER'S MAIDEN NAME First Mary Middle Jane Last Evans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 237-09-2488		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pneumonia and mediastinitis						3 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Dissecting aneurysm, thoracic aorta						2 Years	
DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure						2 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic cardio-vascular disease							
19a. DATE OF OPERATION 28 Apr. 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dissecting Aneurysm		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5 March , 19 69 , to 3 May , 19 69 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 3 May , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE Bradley M. Rodgers, MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 3 May 1969			
22d. PHYSICIAN'S NAME (Type) BRADLEY M. RODGERS				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-6-69		23c. NAME OF CEMETERY OR CREMATORY Stamford, Conn.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR W. W. Chambers ADDRESS 1400 Chapin St. N.W. D.C.				25a. REC'D BY REGISTRAR DATE MAY 6 1969		25b. REGISTRAR'S SIGNATURE William J. Jones	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07164

07160

1 DECEASED NAME (Type or Print) <i>Joseph Michael Morel</i>		First Middle Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>5 23 1969</i>		2b HOUR <i>2:48 PM</i>	
3 SEX <i>male</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>2/9/1921</i>	6 AGE (in years last birthday) <i>48</i> YRS	7 UNDER YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year <i>May 23 1969</i>	
7a BIRTHPLACE (State or foreign country) <i>New York</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Ray Tech</i>		12b KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	
13a U.S.A. RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <i>Md</i>		13b COUNTY <i>Fredricks Mt. Argy</i>		13c CITY OR TOWN <i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>Abel Louis Morel</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Mary Centofant</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16b SOCIA. SECURITY NO <i>W.W. 2 115-05-8775</i>		17. INFORMANT <i>Wife Marguerite Morel</i>		ADDRESS <i>same as above</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe.</i>							<i>4 hrs.</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Trauma from Auto Accident.</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year <i>8:30 PM 5/23 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Car he was driving was struck by another auto</i>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) <i>Highway 705.</i>		21f LOCATION Street or R.F.D. No City or Town County State <i>2 miles South of Montrose - Rockville Montgomery Md</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G. Ball, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>May 23, 1969.</i>	
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>May 26, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>St. Michaels</i>		23d LOCATION (City or Town) (County) (State) <i>Poplar Springs, Md.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Olin L. Molesworth, Damascus, Md.</i>				25a REC'D BY REG STRAR DATE <i>MAY 28 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Rosa			Morris			May Month 14 Day 1969		12:05	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Female		Cauc.		4/12/74		95 YRS.		MONTHS DAYS HOURS M N	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		USA				Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Carriage Hill N. Home		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince Georges		Hyattsville				7333 New Hampshire Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Nathan			Wollberg			Rosalie Abbott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		579148179-D		Mrs. Helen Rubenstein		7333 N. H. Ave. Takoma Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Congestive heart failure due to									
4123 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) Atherosclerotic heart disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 5 Jan, 1969, to 14 May, 1969, that (I) (we) last saw the deceased alive on 13 May, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
Donald B. Doty, M.D. DEGREE				14 May 69					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Donald B. Doty, M. D.				1909 Hanover Street, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 16, 1969		Home of Peace Cemetery		Alexandria, Virginia			
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Donald M. Stein		232 Carroll		MAY 19 1969					
Hebrew Memorial Funeral Home		St., N.W. Wash., D.C.							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with funeral home. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07166		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07162	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or Print)		First <u>Mary</u>		Middle <u>Haje</u>		Last <u>Moses</u>	
2a DATE KNOWN OF DEATH		Month <u>5</u> Day <u>25</u> Year <u>1969</u>		2b HOUR <u>6:00</u> M			
3 SEX <u>Female</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>2-5-11</u>	6 AGE (in years last birthday) <u>58</u> YRS	7 UNDER 24 HRS MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month <u>5</u> Day <u>25</u> Year <u>1969</u>		2d HOUR <u>6:00</u> M
7a BIRTHPLACE (State or foreign country) <u>Lebanon</u>		7b CITIZEN OF WHAT COUNTRY? <u>Naturalized USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10 CITY OR TOWN OF DEATH <u>Cherry Chase</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>8801 Montgomery Ave</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Beautician</u>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased had permanent residence) STATE <u>Md.</u>		13b COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Cherry Chase</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <u>Charles</u> Middle <u>Haje</u> Last <u>Haje</u>		15 MOTHER'S MAIDEN NAME First <u>Shamus</u> Middle <u>Sauid</u> Last <u>Sauid</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b SOCIAL SECURITY NO <u>577-09-8582</u>		17 INFORMANT <u>BROTHER</u> ADDRESS <u>George H Haje - 10021 Tenbank Silver Spring</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u>							<u>sudden</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis</u>							<u>years</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <u>19</u> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>May 26, 1969</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>5-29-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Rockville, Montgomery Co., Md.</u>	
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SON, INC.</u> ADDRESS <u>5130 WISC. AVE., N. W. WASH., D. C. 20018</u>				25a REC'D BY REGISTRAR <u>DAUN</u>		25b REGISTRAR'S SIGNATURE <u>2 1969</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07167

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07163

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR	
JOHN WILLIAM MULLENS								ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/>		May		5		1969		8:45 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	11-18-14		54 YRS		MONTHS 5 DAYS 17		HOURS MIN		May		5		1969		8:45 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH											
Ala.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery											
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY											
Takoma Park		Wash. San. & Hosp.		Manager		Workshop for Blind											
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admn ssion) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER									
Md.		Mont.		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3920 Lantern Dr.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
B. W. Mullens								Ida Bridges									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS											
No				Hospital Records													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				Cardiac Arrest		Intestinal Obstruction											
				Carcinoma of Colon													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
A. S. H. Dis. with old myocardial infarction																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY?													
May 5, 1969		Intest. Obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
CAUSE OF DEATH		HOUR A.M. P.M.		19													
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Belden R. Reap, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED							
EXAMINER'S NAME (Type)		Belden R. Reap, MD		ADDRESS (Street, City, Town, or County)		May 6, 1969											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)											
Burial		5/5/69		Darnestown		Darnestown, Montgomery, Md.											
24 FUNERAL DIRECTOR		1333 Rock Pike		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE											
Tyson Wheeler Funeral Home		Rockville, Maryland		DATE MAY 9 1969		Charles Judge											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07168

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07164

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Dollie Adelaide Murnan			2a. DATE OF DEATH 5 Month 27 Day 69 Year			2b. HOUR 9:50pm	
3. SEX Female		4 RACE White		5. DATE OF BIRTH 11-9-20		6. AGE (in years last birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY, LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 3551 S. Leisure Wld. Blvd.		14. FATHER'S NAME First Middle Last George Bierach		15. MOTHER'S MAIDEN NAME First Middle Last Adelaide Clering			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-05-6822		17 INFORMANT Medical Records Address Montgomery General Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Coronary-Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min. 1 day. years.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 1966 to May 1969 , that (I) (we) last saw the deceased alive on May 27 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard A. Yates, MD		22c. DATE SIGNED 5/28/69		22d. PHYSICIAN'S NAME (Type) Richard A. Yates, MD		22e. ADDRESS Old Baltimore Rd., Olney, Md. 20832	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5.29.69		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Richard Yates			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07169		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07165	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) <i>Warren T. Murphy</i>			2a DATE OF DEATH Month <i>May</i> Day <i>12</i> Year <i>1969</i>			2b HOUR <i>1:15</i> M	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>12-13-03</i>		6 AGE (In years last birthday) <i>65</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>Calif</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Elizabeth</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmer</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Agri.</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>M.D.</i>		13b CITY OR TOWN <i>BETHESDA</i>		13c INSIDE CITY L.M.157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>6307 CATHARINE LANE</i>	
14 FATHER'S NAME First <i>James</i> Middle <i>T</i> Last <i>Murphy</i>			15 MOTHER'S MAIDEN NAME First <i>Orrie</i> Middle <i>L.</i> Last <i>Tuttle</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes a ve war or dates of service) <i>No</i>		16b SOCIAL SECURITY NO <i>577-60-1672</i>		17. INFORMANT <i>Eliz P. Murphy-</i>		Address <i>Same.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Thrombosis, old & Recent</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <i>Coronary thrombosis old & Recent</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Arteriosclerosis - Sclerotic</i> - <i>years.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>-</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes Mellitus -</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc)		21f LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1950</i> , to <i>May</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6 May 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.							
22b SIGNATURE <i>John G. Ball MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>May 12, 1969</i>	
22d PHYSICIAN'S NAME (Type) <i>John G Ball</i>				22e ADDRESS <i>Bethesda, Maryland</i>			
23a. BURIAL CREMATION REMOVAL (Specify)		23b DATE <i>5-13-1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Mountain View Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Oakland, California</i>	
24 FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. ADDRESS <i>5130 WISC. AVE. N. W WASH. D. C. 20016</i>				25a REC'D BY REGISTRAR <i>MAJ 20 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07170

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07166

1 DECEASED-NAME (Type or print) <u>Rose Elizabeth Nichol</u>			2a. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1969</u>			2b. HOUR <u>P. M.</u>					
3 SEX <u>FEMALE</u>		4 RACE <u>Caucasian</u>		5 DATE OF BIRTH <u>9-10-94</u>		6 AGE (In years last birthday) <u>74</u> YRS.		7 UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		8 IF UNDER 24 HRS HOURS <u> </u> MIN <u> </u>	
7a BIRTHPLACE (State or foreign country) <u>Calif.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u> Md					
10 CITY OR TOWN OF DEATH <u>TAKOMA Park</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>WASH. San & Hosp</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Homemaker</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased dwelled, if institution residence before admission) STATE <u>Maryland</u>			13b COUNTY <u>Montgomery Tak. Pk</u>			13c CITY OR TOWN <u>Takoma Park</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>5310 Greenwood Ave</u>	
14. FATHER'S NAME First <u>JAMES</u> Middle <u> </u> Last <u>Macklin</u>			15 MOTHER'S MAIDEN NAME First <u> </u> Middle <u> </u> Last <u> </u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)					
16b SOCIAL SECURITY NO <u> </u>			17 INFORMANT <u>Wash. San. & Hosp. Records.</u> Address <u> </u>								
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Left Cerebral Hemorrhage</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> P.M. <u> </u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) <u> </u>		21f LOCATION Street or R.F.D. No <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>1951</u> to <u>May 22, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b SIGNATURE <u> </u> M.D. DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>5-22-69</u>			
22d PHYSICIAN'S NAME (Type) <u>F. WHITLOCK</u>						22e ADDRESS <u>7717 Canadian Takoma Park</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b DATE <u>May 27, 1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Cemetery</u>				23d LOCATION (City or Town) (County) (State) <u>Adephi. P. Bea Md.</u>			
24 FUNERAL DIRECTOR <u>Arthur Walters Washington, D.C. 20012</u>				25a. REG. BY REGISTRAR DATE <u>MAY 27 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Gorge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 413
45M 1969

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Wilbur OWEN Nichols						Month 5 Day 14 Year 1969			10:05 PM					
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS			
Male		White		7-29-1897			71 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Md			U.S. of America						Montgomery			Md		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park				Washington Sen + Hospital				Railroad - retired						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md				V		Howard Fulton		YES <input type="checkbox"/> NO <input type="checkbox"/>		Route 216				
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Frank Nichols			Annie ?											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17 INFORMANT		Address						
						Washington Sen + Hospital Records		Takoma Park Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)														
7 Cordial failure														
DUE TO, OR AS A CONSEQUENCE OF														
(b) Respiratory failure														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
				HOUR AM P.M. Month Day Year 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5-5, 1969, to 5-14, 1969, that (I) (we) last saw the deceased alive on May 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE				22c. DATE SIGNED										
[Signature]				5/14/69										
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial				5/17/69		Savage Cemetery		Savage Md.						
24. FUNERAL DIRECTOR				25a. RECD BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Donald J. H.				MAY 22 1969				[Signature]						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

Item 28 Film 413 6-5-69 and MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07172 CERTIFICATE OF DEATH 07168									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P
Linwood			Vernon	Nicholson	May 23 1969			7:50 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Sept. 7, 1913		55 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hosp.		owner/manager		Service Sta.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Carroll		Woodbine				Route 1	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Harry			Nicholson			Beulah			King
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(1 yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address
yes			WW 2		213-01-6796		Montgomery General Hospital, Olney, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>									9 mos.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Site of origin unknown.</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 8, 1969</u> , to <u>May 23, 1969</u> , that (I) (we) last saw the deceased alive on <u>5-23-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frederick Mooman, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-23-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Frederick Mooman, M.D.</u>						22e. ADDRESS <u>Sandy Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			5/26/1969		Morgan Chapel		Carroll, Md.		
24. FUNERAL DIRECTOR <u>C. M. Waltz, Box 241, Sykesville, Md.</u>						25a. RECD BY REGISTRAR <u>MAY 27 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

James R. Coleman M.D.

1 DECEASED NAME (Type or print) First Middle Last Heleen Louise O'Connor		2a. DATE OF DEATH Month Day Year 5 17 69		2b. HOUR 1:13
3 SEX female	4. RACE Caucasian	5. DATE OF BIRTH 8/2/91	6 AGE (In years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Wash D C	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Sil. Spg.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife	12b. KIND OF BUSINESS OR INDUSTRY on home	
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE MD	13b. COUNTY Mont.	13c. CITY OR TOWN Sil. spg.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2104 Belvedere Blvd.
14. FATHER'S NAME First Middle Last unknown	15. MOTHER'S MAIDEN NAME First Middle Last unknown	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16b. SOCIAL SECURITY NO 220-541-5428		17. INFORMANT Robert F. O'Connor		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest. 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (c) A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. year.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (1) (this hospital) attended the deceased from Aug , 1967, to Apr , 1969, that (1) (we) lost saw the deceased alive on Apr. 15 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (1) (we) (did) (did not) view the body after death.				
22b. SIGNATURE James R. Coleman M.D.	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED May 17, 1969	
22d. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN	22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 20, 1969	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR James E. P. Phipps, Jr.	ADDRESS 8434 Avenue 11, Silver Spring, Md.	25a. REC'D BY REGISTRAR MAY 20 1969	25b. REGISTRAR'S SIGNATURE Charles J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07174

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07170

1 DECEASED NAME (Type or print) LAWRENCE ADOLPH ORTQUIST			2a DATE OF DEATH Month 5 Day 31 Year 69		2b. HOUR 2⁰⁰ P.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH 2-2-07		6 AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) MICHIGAN	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md	
10 CITY OR TOWN OF DEATH TAKOMA PARK	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON + SAN. + HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CABINET MAKER		12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.	13b COUNTY MONTGOMERY	13c CITY OR TOWN WHEATON	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 12031 BLUHL RD	
14 FATHER'S NAME First Middle Last AMIL ORTQUIST			15 MOTHER'S MAIDEN NAME First Middle Last EVA LUNDSTRUM		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b SOCIAL SECURITY NO 368-01-1414	17 INFORMANT Marion Miller Address Wash. San. Hospital		
18 CAUSE OF DEATH (Enter on any one cause per line for (a) (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 403X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIT ON GIVEN IN PART I(a)					
19a DATE OF OPERATION May 28, 69		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Renal Biopsy		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21c LOCATION Street or R.F.D. No City or Town County State	
22a I certify that (I) (th's hospital) attended the deceased from April 23, 1969 to May 31, 1969 that (I) (we) lost saw the deceased alive on May 31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE Henry M. Wise, Jr.		22c DATE SIGNED 2 June 69		22d PHYSICIAN'S NAME (Type) HENRY M. WISE, JR.	
23 BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 6-4-69	23c NAME OF CEMETERY OR CREMATORY PARKLAWN		23d LOCATION (City or Town), (County) (State) ROCKVILLE, MD.
24 FUNERAL DIRECTOR Wm Chambers Co.		25g REC'D BY REGISTRAR JUN 9 1969		25b REGISTRAR'S SIGNATURE John J. [Signature]	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										07171		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07171		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR
LAWRENCE			BRUCE	OSTERMAN	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 24 HRS	MONTHS	DAYS	HOURS	MIN.	2c. DATE PROMOUNCED DEAD		2d. HOUR	
Male	White	11/28/1964	4 YRS.						Month 5 Day 12 Year 1969		5:55 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
DASH., DC		U. S.				Montgomery Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Holy Cross Hosp.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Md.			Montgomery			Sil. Sp.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER						
Leonard			Osterman			Eva			Horovitz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
						Leonard Osterman			1607 Peacock Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxiation due to</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) <u>Drowning</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)								
CAUSE OF DEATH		5:55 PM 5-12-69		deceased child fell into pool and drowned								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or town		County		State		
		Home		13310 Collingwood Terr.		S.S. Montg		Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED				
EXAMINER'S NAME (Type)		Belden R. Reap M.D.						May 12, 1969				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		May 13, 1969		King David Memorial Garden		Falls Church, Va.						
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Bernard Danzansky & Sons						MAY 15 1969						
3501 14th St., N.W., Washington, D.C.												

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 413
6-3-69 ams
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07176 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07172

1 DECEASED NAME (Type or Print) Raymond Duppy Ottey				2a DATE KNOWN OF EST- DEATH MATED <input checked="" type="checkbox"/> 5 20 1969 5 45 PM				2b HOUR	
3 SEX M.	4 RACE W.	5 DATE OF BIRTH 2/18/1930	6 AGE (In years lost in theory) 39 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month May Day 20 Year 1969		2d HOUR 5 45 PM	
7a BIRTHPLACE (State or foreign country) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 120811 Twinbrook Pky		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Plasterer		12b KIND OF BUSINESS OR INDUSTRY			
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 120811 Twinbrook Pky	
14. FATHER'S NAME First William Middle Ottey Last Ottey				15. MOTHER'S MAIDEN NAME First Glema Middle Maddy Last Ottey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 579-36-1674		17. INFORMANT Kaye M. Ottey (Above address)				ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PLANNED Barbiturate poisoning (b) Overdose of barbiturates (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 4:50 PM 5/20 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Took overdose of barbiturates					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory office building, etc.) Home		21f LOCATION Street or R.F.D. No City or Town County State 120811 Twinbrook Pky. Rockville Montg. Md.					
22a. I certify that, I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John E. Bell EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED May 21, 1969	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/23/69		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d LOCATION (City or Town) (County) (State) Colmar Manor, Md.			
24 FUNERAL DIRECTOR Nalley's Funeral Home				ADDRESS Mt. Rainier, Maryland		25a REC'D BY REGISTRAR MAY 26 1969		25b REGISTRAR'S SIGNATURE W. Charles Judge	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

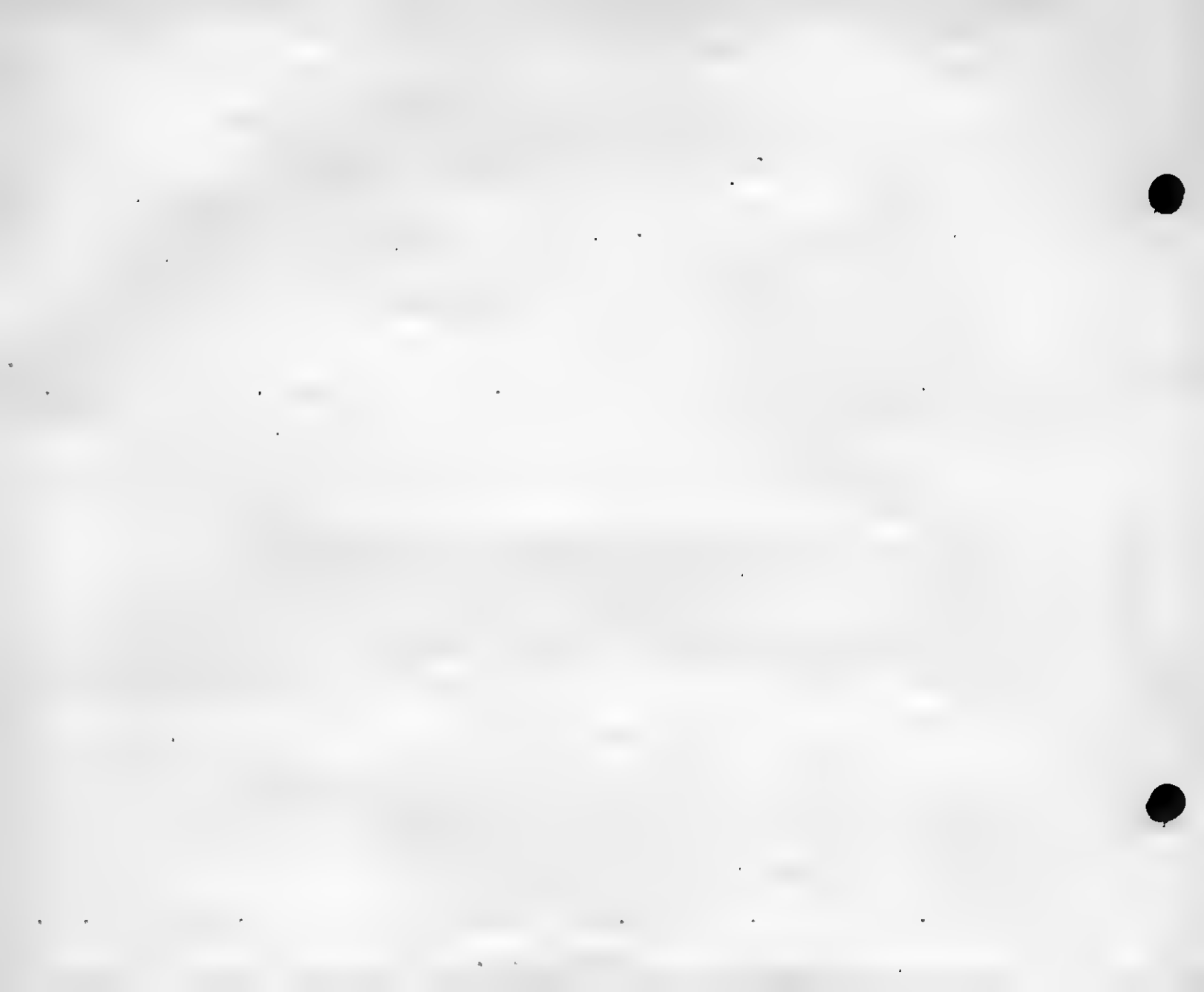
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07177

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07173

1. DECEASED NAME (Type or Print) <i>George David Overholtzer</i>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>5</i> Day <i>11</i> Year <i>1969</i>		2b. HOUR <i>4:55</i> P.M.
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Oct. 8, 1915</i>	6. AGE (In years last birthday) <i>53</i> YEARS	7. IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>
7a. BIRTHPLACE (State or foreign country) <i>PA.</i>		7b. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Sabotek</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
13a. USUAL RESIDENCE (Where deceased lived, if institution address on) STATE <i>Md.</i>		13b. COUNTY <i>Mont. Kensington</i>	13c. CITY OR TOWN <i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. INS. DE CITY, M.F.S. <i></i>
14. FATHER'S NAME <i>Melvin Overholtzer</i>		15. MOTHER'S MAIDEN NAME <i>Mary Recklee</i>		16. ADDRESS <i>Silver Springs Md.</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>Yes 1944-1945</i>		16b. SOCIAL SECURITY NO. <i>214-16-7225</i>		17. INFORMANT <i>Mrs. George Overholtzer, 11704 Idlwood Rd.</i>
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Failure, Pulmonary Edema.</i>				<i>2h.</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Broncho Pneumonic Confluent.</i>				<i>4 days.</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Alcoholism.</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>May 12, 1969</i>
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May 14, 1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. View Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Emmitsburg, Frederick Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Clarence E. Wilson</i>		ADDRESS <i>Emmitsburg, Md.</i>		25a. RECD BY REGISTRAR <i>May 15 1969</i>
				25b. REGISTRAR'S SIGNATURE <i>John G. Ball</i>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and on any event within 72 hours after death.

Items 18-22a Form 413 MARYLAND STATE DEPARTMENT OF HEALTH
6-12-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07174

1 DECEASED-NAME (Type or Print)		First JERRY HUGH PAGE		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5-22-1969		2b HOUR 8:50	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 7-5-60		6 AGE (In years last birthday) YRS 10	IF UNDER 1 YEAR MONTHS 17		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 5-22-1969		2d HOUR 8:50
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Tatoma Park, Id.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. Jan. & Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived admission) STATE Md.		13b COUNTY P.G.		13c CITY OR TOWN S.S.		3d INSIDE CITY, MARYLAND? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 100-C Ames Road			
14. FATHER'S NAME First Middle Last Francis Page				15. MOTHER'S MAIDEN NAME First Middle Last Lucille Cunningham							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Mother		ADDRESS 100-AMES Rd, Silver Spring, Md.					
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries with DUE TO, OR AS A CONSEQUENCE OF (b) exsanguination incurred when struck DUE TO, OR AS A CONSEQUENCE OF by auto (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 8 HOUR 5-22 19 69 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) Deceased, crossing highway, was struck by auto.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) Street -- New Hamp Ave & Southampton Dr. Silver Spring Md.		21f. LOCATION Street or R.F.D. No		City or Town		County Montgomery State			
22a. I certify that I took charge of the remains described above, held in death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Balden R. Reap, MD		EXAMINER'S NAME (Type)		Balden R. Reap, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED MAY 22, 1969			
23a. BURIAL (CREMATION, REMOVAL) (Specify)		23b. DATE 5-26-69		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City or Town) (County) (State) Montgomery County					
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557-Wisconsin Ave., Bethesda, Md.						25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE William J. Gage			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Filed 5/29/69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07179 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07175											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
HANS PETER PAIKERT						Month 5 Day 20 Year 1969			5:15 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
MALE	W.	11-11-1899	69 YRS	MONTHS DAYS	HOURS MIN	Month 5 Day 20 Year 1969			5:30 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
GERMANY		NATURALIZED				MONTGOMERY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. U.S.A. OCCUPATION (Kind of work done during most of work on life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
ROCKVILLE		5630 FISHERS LANE				ENGINEER			DELIVERMENT		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)				13b. COUNTY		13c. CITY OR TOWN		3d. ASIDE CITY, STATE		13e. STREET AND NUMBER	
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2308 POPLAR DRIVE	
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last		
UNKNOWN						UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
NO			186-10-7854			Richard M. Elworthy			2308 Poplar Drive 21207		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
4109 Coronary Occlusion Acute -											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Coronary Arterio Sclerosis -										years	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from											
Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John E. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			May 21, 1969		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		May 23, 1969		Meadow Ridge Cemetery		Howard Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Loring Byers Chapel 8728 Liberty Road 21133						DATE MAY 23 1969		W. Charles Judge			
Randallstown, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07180					07176					
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH			2b HOUR		
HARRY PETER PAEOLOGOS					Month 5 Day 20 Year 1969			9:25 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		2-23-92		7 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
GURNEY EUROPE		AMERICAN				MONTGOMERY Md				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK			WASHINGTON SAN. & Hosp.			BARBER				
13a USLA RESIDENCE (Where deceased lived, if instituton admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND			MONTGOMERY		S.S.				18 INDIAN SPRING DR.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last	
PETER					PAEOLOGOS	MARIA			BARBIS	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT			Address		
No			579-18-4742		HOSPITAL RECORD, TAKOMA PARK, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE HOURS.										
4123 DUE TO, OR AS A CONSEQUENCE OF										
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) BRONCHO PNEUMONIA DAYS										
DUE TO, OR AS A CONSEQUENCE OF										
(c) ARTERIOSCLEROTIC HEART DISEASE YRS.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
CEREBRAL ARTERIOSCLEROSIS ADVANCED										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED Where <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f LOCATION		Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from STARTED, 1966, to MAY 20, 1969, that (I) (we) lost saw the deceased alive on MAY 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE		22c DATE SIGNED								
ALBERT H. GROLLMAN MD		5/21/69								
22d PHYSICIAN'S NAME (Type or print)		22e ADDRESS								
ALBERT H. GROLLMAN		1106 SIRKING ST., SILVER SPRING								
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town)		(County) (State)		
BURIAL		23 MAY 1969		GLENWOOD CEMETERY		WASHINGTON DC.		MD		
24 FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
RINALDI FUNERAL HOME, INC., 700 CA. AVE. NW, #20012					MAY 23 1969		Charles Judge			

Page 4 may be retained by the hospital or attending physician.

VR
45M

07181

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

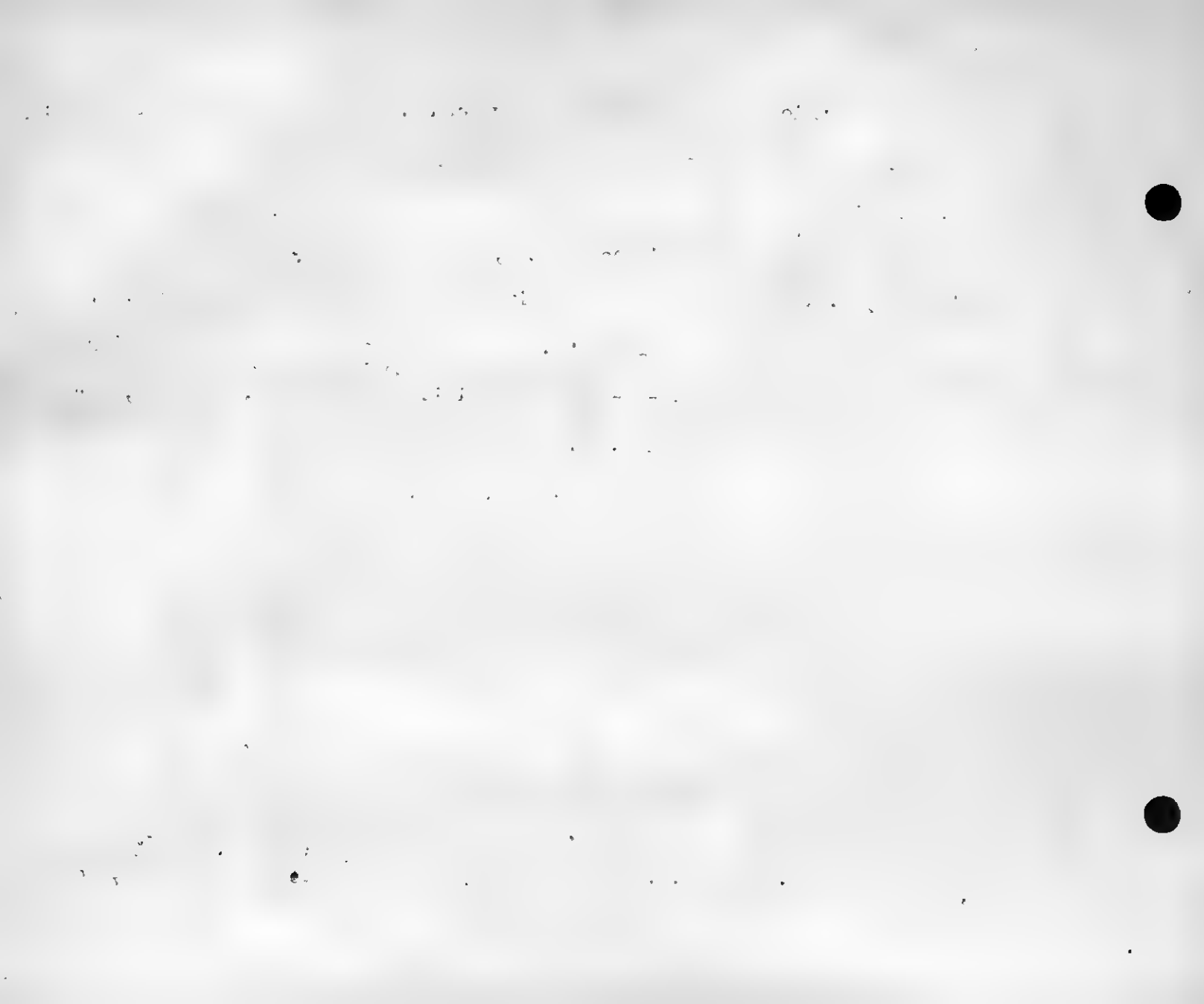
07177

1. DECEASED NAME (Type or print)		First Raymond		Middle Clay		Last Parker		2a DATE OF DEATH 5 Month 21 Day 69 Year		2b HOUR 10A.M.	
3. SEX Male		4 RACE Negro		5 DATE OF BIRTH March 7, 1893				6 AGE (In years lost birthday) 76 YRS.		F UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Jefferson, Va.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Wheaton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Janitor				12b KIND OF BUSINESS OR INDUSTRY			
13a USUA. RES DENCE (Where deceased admission) STATE D.C.		ved, if institution. Residence before 13b COUNTY Washington		13c CITY OR TOWN Washington		13d INS DE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4719 Foote St., N.E.			
14. FATHER'S NAME First Middle Last Sandy Parker				15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO 197-07-6798		17 INFORMANT Address William P. Parker 4719 Foote St NE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Myocardial Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Thrombosis and Atherosclerosis of Coronary Arteries</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> <u>6 Weeks</u> <u>5 Yrs</u>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Essential Arteriosclerosis; Atherosclerosis</u>											
19a DATE OF OPERATION —		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11/69</u> to <u>5/21/69</u> , that (I) (we) last saw the deceased alive on <u>5/1/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Edward C. Maniquez</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>5/21/69</u>	
22d PHYSICIAN'S NAME (Type) <u>Edward C. Maniquez</u>		22e ADDRESS <u>1801 21st St. N.W. Wash D.C.</u>									
23a BURIAL, CREMATION, REMOVAL (Specify) <u>5-34-69</u>		23b DATE		23c NAME OF CEMETERY OR CREMATORY <u>Harmory</u>				23d LOCATION (City or Town) (County) (State) <u>Highland Park Md</u>			
24 FUNERAL DIRECTOR, <u>H. B. Wark & Son</u> <u>4925 Pine Mt Rd</u>				ADDRESS		25a REC'D BY REGISTRAR DATE <u>26 1969</u>		25b REGISTRAR'S SIGNATURE <u>Richard J. Under</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07182				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07178					
Items #23a, thru, d & 24, Film 34, 13 6/1				CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)				First Middle Last				2a. DATE OF DEATH Month Day Year				2b. HOUR P	
Sammie				(none)				Parker, Jr.				May 10 1969 10:35 AM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (in years last birthday)		F. UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		Negro		30 January 1938				31 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.					
North Carolina		USA											
1d. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda				The Clinical Center, NIH				Driver Messenger					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Washington, D.C.				Washington				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5011 12th Street, N.E.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Sammie Parker, Sr.				Vila Parker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO				17. INFORMANT The Medical Record Address					
No				245-54-6345				The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Intracerebral hemorrhage												3 days	
DUE TO, OR AS A CONSEQUENCE OF													
(b) Chronic myelogenous leukemia												1 year	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 8 May 1969, to 10 May 1969, that (X) (we) last saw the deceased alive on 10 May 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.													
22b. SIGNATURE Peter G. Burk M.D.				22c. DATE SIGNED 11 May 1969				22d. PHYSICIAN'S NAME (Type) Peter G. Burk, M.D.					
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE May 15, 69				23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Church Cem.				23d. LOCATION (City or Town) (County) (State) Bahama Durham N.C.	
24. FUNERAL DIRECTOR Jones & Sons, Ellis O., 415 Dowd St., Durham, N.C.				25a. REC'D BY REGISTRAR DATE MAY 15 1969				25b. REGISTRAR'S SIGNATURE					



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07179

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Miller		Vernon	PARSONS		May 11 1969		1130M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male	Caucasian		Nov. 14, 1882		86 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Ohio	USA				Montgomery				
10. CITY OR TOWN OF DEATH		1. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Naval Hospital		U.S. Marine Corps		N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Bethesda		YES		4706 Glenbrook Parkway	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT	
James		Parsons		Mary		Bethesda, Md.		Address	
						Mrs. Naomi Parsons		4706 Glenbrook Parkway	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Coronary artery disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>March 14</u> , 19 <u>69</u> , to <u>May 11</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>May 11</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>E. M. Jewusiak</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>E. M. JEWUSIAK, M. D..</u>				22e. ADDRESS <u>Naval Hospital, Bethesda, Maryland</u>		May 12, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-15-69		Arlington National		Arlington Va.			
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Funeral Home</u>				25a. REC'D BY REGISTRAR <u>MAY 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
7557 Wisconsin Ave., Bethesda, Md.									



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07184

07180

1 DECEASED-NAME (Type or print) Herba Baker			First Middle Last Patterson			2a. DATE OF DEATH Month May Day 2 Year 1969			2b. HOUR AM PM 6:12 AM					
3 SEX Female			4 RACE White			5. DATE OF BIRTH 26 September 1897			6 AGE (In years last birthday) 71 YRS.					
7b. BIRTHPLACE (State or foreign country) Alabama			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk			12b. KIND OF BUSINESS OR INDUSTRY US Gov't					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Alabama			13b. COUNTY Tuscaloosa			13c. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>			13e. STREET AND NUMBER 1311 12th Avenue					
14. FATHER'S NAME First Middle Last Herbert H. Baker			15. MOTHER'S MAIDEN NAME First Middle Last Mahulda Spradling			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) --			16b. SOCIAL SECURITY NO 579-60-5456					
17 INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center,			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Gram-negative sepsis 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 174X DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia, bilateral DUE TO, OR AS A CONSEQUENCE OF (c) ? metastatic breast ca., right adrenal gland & APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours days months			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute Granulocytic Leukemia								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that Dr. (this hospital) attended the deceased from 23 February, 1969 , to 2 May, 1969 , that he (we) last saw the deceased alive on 2 May, 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (do not) view the body after death.														
22b. SIGNATURE Dr. Riddick, MD						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 2 May 1969					
22d. PHYSICIAN'S NAME (Type) David H. Riddick, MD.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE 5-3-1969			23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery			23d. LOCATION (City or Town) (County) (State) Birmingham, Alabama					
24 FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016						25a. REC'D BY REGISTRAR MAY 8 1969			25b. REGISTRAR'S SIGNATURE W. L. L. L. L.					



1538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07181

1 DECEASED NAME (Type or print) <i>Winfield S Pealer</i>			2a DATE OF DEATH Month <i>May</i> Day <i>29</i> Year <i>1969</i>		2b HOUR <i>6:05 PM</i>
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>Nov. 8 1886</i>		6 AGE (In years last birthday) <i>88</i> YRS.	7 IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>
7a BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Montgomery</i>		Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>LAWYER</i>	
12b KIND OF BUSINESS OR INDUSTRY <i>LAW</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>3362 Glenridge Dr</i>			
14 FATHER'S NAME <i>Robert A Pealer</i>		15 MOTHER'S MAIDEN NAME <i>Katherine Caines</i>		Address <i>3362 Glenridge Dr S. Sp.</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or Unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>297-32-4977</i>		17 INFORMANT <i>Mayme Pealer</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic carcinoma colon</i>					
1538 DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <i>19</i> Month <i>5</i> Day <i>28</i> Year <i>1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/28</i> , 19 <i>69</i> , to <i>5/29</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/29</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <i>Wynon G. Jenkins MD</i>		DEGREE <i>MD</i>		22c DATE SIGNED <i>5/29/69</i>	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS <i>2309 Shorefield Rd Wheaton Md</i>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>6-3-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Baltimore Natl. Cem.</i>	
23d LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>					
24 FUNERAL DIRECTOR <i>W. W. Chambers Co.</i>		ADDRESS <i>1655 Lexington Sil Sp</i>		25a RECD BY REGISTRAR <i>JUN 4 1969</i>	
25b REGISTRAR'S SIGNATURE <i>Charles Jones</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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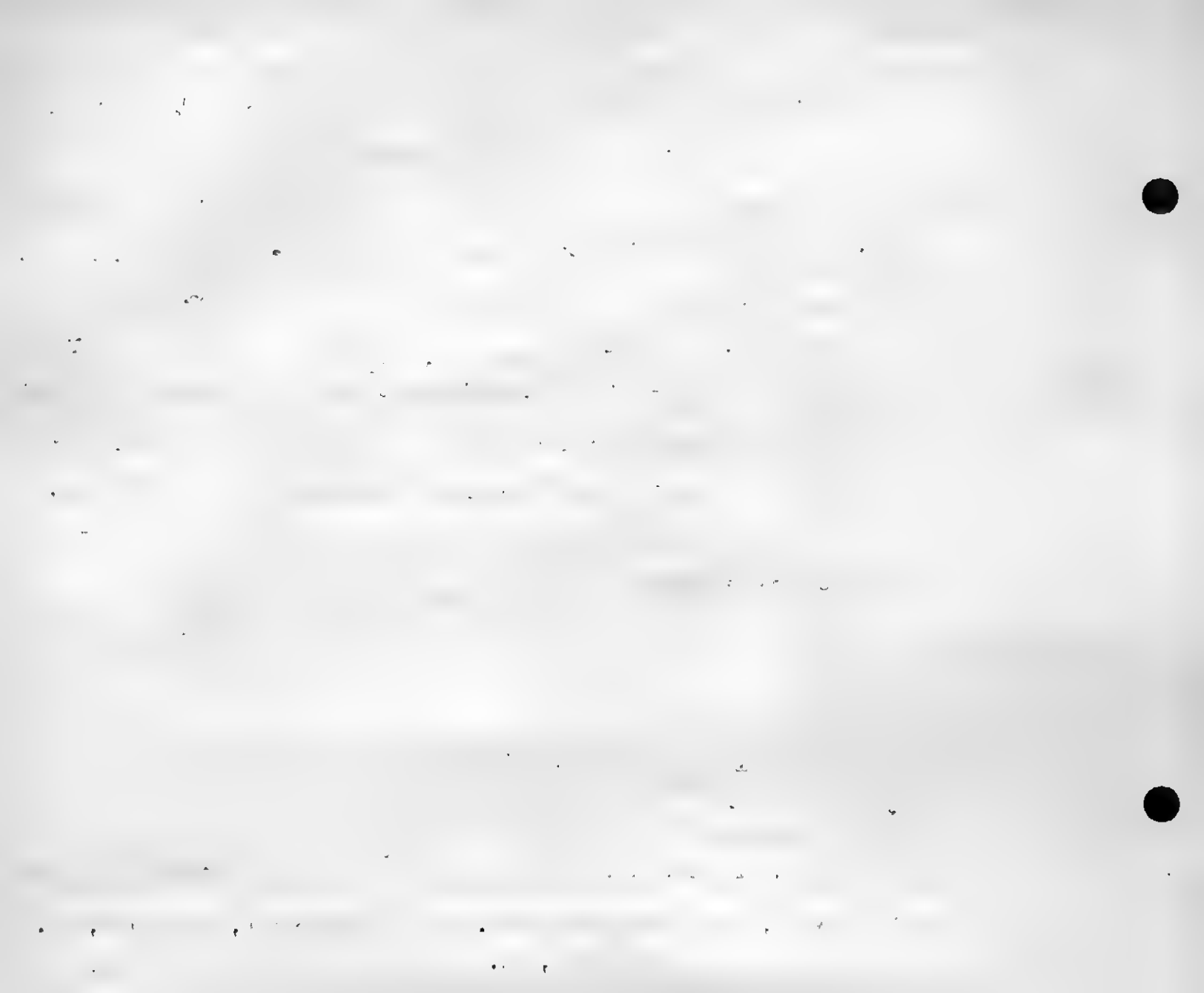
07186

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07182

1. DECEASED-NAME (Type or print) Curtis Blake Peer			2a. DATE OF DEATH Month May Day 14 Year 1969			2b. HOUR P 9:45 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 16 September 1941		6. AGE (In years last birthday) 27 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admision) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Falls Church		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1915 Hileman Road	
14. FATHER'S NAME First Middle Last Jetson R. Peer			15. MOTHER'S MAIDEN NAME First Middle Last Pearl Foltz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 233-66-5371		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Massive gastrointestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Intravascular coagulation								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 12 hours 24 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute Myelogenous Leukemia 8 weeks									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 8 April , 1969 , to 14 May , 1969 , that (X) (we) lost the deceased alive on 14 May , 1969 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David H. Riddick MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 14 May 1969			
22d. PHYSICIAN'S NAME (Type) David H. Riddick, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 17, 1969		23c. NAME OF CEMETERY OR CREMATORY Shenandoah Mem. Park		23d. LOCATION (City or Town) (County) (State) Winchester, Frederick, Va.			
24. FUNERAL DIRECTOR Harold M. Baggett				ADDRESS Winchester, Va.		25a. REC'D BY REGISTRAR MAY 19 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

07187										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										7183	
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR	
Ethel P. Persons										May 21 1969										1:03 PM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.									
Female		Caucasian		9/22/85				83 YRS.													
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH									
Corning, New York				U.S.A.								Montgomery				Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring, Md.				Colonialville Nursing Home				Reg. Nurse													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY, MTS. YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER											
Maryland				Montgomery		Takoma Park				1001-Houston Ave.											
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last																	
Russell Pierce				Jennie																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (* yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address															
No				266-36-8220		MRS. MARY JANE PETTIT, 1001 HOUSTON AVE															
18. CAUSE OF DEATH (Enter any one cause per line far (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute respiratory Failure														1 week							
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic bronchitis and emphysema														20-30 yrs							
DUE TO, OR AS A CONSEQUENCE OF (c) Tracheostomy for 40 years																					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
Arteriosclerotic heart disease																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CASE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from Sept 1968, to May 20, 1969, that (I) (we) last saw the deceased alive on May 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED																					
Bernice A. Bandman MD 5/21/1969																					
22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS																					
10820 GEORGIA AVE WHEATON, MD																					
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
Burial				May 23, 1969				Arlington National				Arlington Virginia									
24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																					
Takoma Funeral Home, Inc. J. A. Walters, 254 Carroll St NW MAY 23 1969																					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07188		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07184	
Item 6 Film 612 5/9/69 kk		CERTIFICATE OF DEATH			
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH
IRIS		L.		PFEIFFER	Month - Day - Year
3 SEX		4 RACE		5 DATE OF BIRTH	6. AGE (In years last birthday)
FEMALE		WHITE		4-23-23	46 YRS
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH
Ohio		USA			Montgomery County, Md.
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Silver Spring, Md.		Holy Cross		Secretary. U.S. Govt.	
13a USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d IS DE CITY L.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md.		Montgomery		Silver Spring	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME
Fred M.				Schaber	Mabel Alice Landrum
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT	
no		yes		Silver Spring, Md. John Leo Pfeiffer (husband)	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 18-0					few weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of ovary					18 mo.
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>but</u> , 19 <u>68</u> , to <u>5/1</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>5/1</u> 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death					
22b SIGNATURE <u>G. Lennard Gold</u>				22c. DATE SIGNED <u>5/2/69</u>	
22d PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>				22e ADDRESS <u>9801-Ga. Ave. Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)
Burial		May 5, 1969	Gate of Heaven Cemetery		Silver Spring, Maryland
FURNERAL DIRECTOR <u>Varner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Ga Avenue Silver Spring, Md.</u>		25a REC'D BY REGISTRAR <u>MAY 7 1969</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

07185

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07185

Item #3, Film #413 6/12/69 km

1. DECEASED-NAME (Type or print) WILLIAM H. PFOHL		2a. DATE OF DEATH Month 5 Day 7 Year 69		2b. HOUR 3:47 PM
3 SEX M.	4. RACE W.	5. DATE OF BIRTH 5-17-11	6 AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) HUNGARY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chauffeur	12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USLA RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Prince George's	13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5023-Riverdale Road
14. FATHER'S NAME First Wenzel Middle Pfohl Last Hild		15. MOTHER'S MAIDEN NAME First Rosa Middle Hild Last Hild		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service.) NO		16b. SOCIAL SECURITY NO -		17. INFORMANT Rosa H. Pfohl - (above address)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 441.2 BLEEDING ABDOMINAL AORTIC ANEURYSM DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) INFECTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS YEARS 3-4 WEEKS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 1952 , 19, to 7 MAY 1969 , that (I) (we) last saw the deceased alive on 7 MAY 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Harry R. Wolfe		22c. DATE SIGNED 7 MAY 69		22d. PHYSICIAN'S NAME (Type) W.D. DEGREE
22e. ADDRESS 1131 UNIVERSITY BLVD W., S.S. MD		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMAINS Burial	23b. DATE 5/10/69	23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cem.	23d. LOCATION (City or Town) (County) (State) Suitland, Md.	23e. REC'D BY REGISTRAR MAY 12 1969
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25b. REGISTRAR'S SIGNATURE John F. Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



07190

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07186

Items 586 Film 413 6/6/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Sophie			Helen Philippy			May 24 1969			12:03 M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		8/30/94 1892			18/9 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.					
Russia		U. S. A.					Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Olney			Montgomery General Hosp.			Domestic			housework					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Montgomery			Silver Spring			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3521 S. Leisure World Blvd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Julius Stark			Matilda Kramer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address					
No (unknown)			002-24-9233			records			Montgomery General Hospital, Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction (second)</u>											15 min.			
DUE TO, OR AS A CONSEQUENCE OF														
(b) <u>Coronary Heart Disease</u>											1 yr.			
DUE TO, OR AS A CONSEQUENCE OF														
(c) <u>Arteriosclerosis</u>											years.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. Month Day Year											
			P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State					
						Sept 1968			May 1969					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1968</u> to <u>May 1969</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>May 22 1969</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did not</u>) view the body after death														
22b. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
<u>Richard A. Yates</u>						DEGREE			5/24/69					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS								
Richard A. Yates, M. D.						Old Baltimore Road, Olney, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			5/26/69			Cedar Hill			Suitland, Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey Inc. 8434 Ga. Ave. Silver Spring, Md.						MAY 27 1969			Charles Judge					

Cleared by Medical Examiner, Beldon R. Peapack, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07191

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <u>Terrey Wilson Phillips</u>			2a DATE OF DEATH <u>5</u> Month <u>15</u> Day <u>69</u> Year		2b HOUR <u>2:15</u> M
3 SEX <u>Male</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>6-2-92</u>		6 AGE (In years last birthday) <u>76</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTH PLACE (State or foreign country) <u>New York</u>	7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u> Md.	
10 CITY OR TOWN OF DEATH <u>Bethesda</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Attorney</u>		12b KIND OF BUSINESS OR INDUSTRY <u>LAW</u>
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>	13b COUNTY <u>Mont.</u>	13c CITY OR TOWN <u>Gaithersburg</u>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <u>3963 Rosemary St.</u>	
14 FATHER'S NAME First <u>WILSON</u> Middle <u>E.</u> Last <u>PHILLIPS</u>		15 MOTHER'S MAIDEN NAME First <u>KATIE</u> Middle <u>-</u> Last <u>BAIRD</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <u>Yes</u> (Yes, no, or unknown) <u>U.S.A.</u>		16b SOCIAL SECURITY NO		17 INFORMANT <u>Wife-Betty Phillips-Same As #13</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>515X METABOLIC ALKALOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema and congestion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastric hemorrhage, diffuse</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ARTERIO SCLEROTIC HEART DISEASE, OLD MYOCARDIAL INFARCTION, CHOLECYSTECTOMY</u>					
19a DATE OF OPERATION <u>5-13-69</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>subacute cholecyphria</u>		20a AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12</u> , 19 <u>69</u> , to <u>5-15</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>5-15-69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>John C. Robben M.D.</u>		DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>5-15-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>John C. Robben M.D.</u>		22e ADDRESS <u>10400 CONNETT COT AVE KENSINGTON MD</u>			
23a. BURIAL, CREMATION, REMOVA (Specify) <u>CREMATION</u>	23b. DATE <u>5/19/69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND MD.</u>	
24. FUNERAL DIRECTOR <u>JOSEPH SAWLER'S SONS, 5130 WISCONSIN AVE. WASHINGTON, D.C.</u>		25a REC'D BY REGISTRAR <u>MAY 21 1969</u>		25b REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07192

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07188

1. DECEASED NAME (Type or print) First Middle Last Jessie Y.A. Pierce		2a. DATE OF DEATH Month Day Year May 4 1969		2b. HOUR 2:25 PM
3. SEX Female	4. RACE white	5. DATE OF BIRTH 1-18-17	6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? America	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if in hospital or institution) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INS. DE. CITY LHM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 910 South Belgrade Road
14. FATHER'S NAME First Middle Last N.D. Baron	15. MOTHER'S MAIDEN NAME First Middle Last Ida Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO 225-18-5777	17. INFORMANT Address Patient's chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) HEMORRHAGING ESOPHAGEAL VARICES DUE TO, OR AS A CONSEQUENCE OF (b) INTERPORTAL CIRRHOSIS OF THE LIVER DUE TO, OR AS A CONSEQUENCE OF (c) 5718 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-26, 1969 , to 5-4, 1969 , that (I) (we) last saw the deceased alive on 5-3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Abraham W. Danisat		22c. DATE SIGNED 5-4-69		
22d. PHYSICIAN'S NAME (Type) ABRAHAM W. DANISAT		22e. ADDRESS 1106 SPRING ST S.E.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-6-69	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR ADDRESS F. J. Collins 500 Univ. Blvd. W. Sil. Sp. Md.		25a. REC'D BY REGISTRAR DATE MAY 7 1969	25b. REGISTRAR'S SIGNATURE W. L. L. Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07189	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year		2b HOUR
Mary VanVeen Pilson						MAY 25 1969			2 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Fe-	W.	10/11/32	36 YRS	MONTHS DAYS		HOURS MIN		MAY 26 1969		2 PM	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Washington, DC			USA						Montgomery Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			6800 Wisconsin Ave In town Motel			Housewife			Home		
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			3d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Md.			Montgomery			Brookmont			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4016-62 St
14 FATHER'S NAME First Middle Last						15 MOTHER'S MAIDEN NAME First Middle Last					
Eugene Benjamin VanVeen						Louise Larcombe					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
no				577-42-3305		Benjamin F. Pilson Brookmont, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drug Poisoning										1/2 hr.	
9502 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost											
(b) overdose Librium + Barbituates											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				2 PM 5/25 1969				Took overdose Librium + Barbituates			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or RFD No City or Town County State			
				Motel				6800 Wisconsin Bethesda Montgomery Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				MAY 26, 1969			
John G. Ball				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				BETHESDA, MD.			
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation				28 May 69		Cedar Hill Crematory		Suitland Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Bethesda, Maryland						JUN 5 1969		[Signature]			

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner Beldon R. Reap,

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Haywood			First Middle Last (NMN) Prather			2a. DATE OF DEATH Month 5 Day 24 Year 1969		2b. HOUR 2:00AM	
3. SEX Male		4. RACE C		5. DATE OF BIRTH 6-7-26		6. AGE (In years last birthday) 42 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Janitor		12b. KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institut on Residence before adomission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sandy Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 187 Sandy Spring, Md.	
14. FATHER'S NAME First Middle Last Irvin G. Prather			15. MOTHER'S MAIDEN NAME First Middle Last Mamie B. Prather						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) 1944-46			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Hypertensive C.V. - Renal Disease (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 yr. 2 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1963 , to 5/24 , 1969, that (I) () last saw the deceased alive on 5/17 , 1969, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () () () view the body after death									
22b. SIGNATURE Charles H. Ligon, M.D.		22c. DATE SIGNED 5/24/69		22d. PHYSICIAN'S NAME (Type) Charles H. Ligon, M.D.		22e. ADDRESS Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/27/69		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Laytonsville, Montg., Md.			
24. FUNERAL DIRECTOR George R. Snowden		25a. REC'D BY REGISTRAR Rockville		25b. REGISTRAR'S SIGNATURE Charles Judge		MAY 28 1969			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician ~~and~~ completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages ~~Pages 1 and 2~~ should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~many event~~ with ~~72~~ 72 hours after death.

<div style="display: flex; justify-content: space-between;"> MARYLAND STATE DEPARTMENT OF HEALTH 07191 </div> <div style="display: flex; justify-content: space-between;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07191 </div> <h2 style="text-align: center; margin: 0;">CERTIFICATE OF DEATH</h2>											
1 DECEASED NAME <small>(Type or print)</small> <div style="display: flex; justify-content: space-between;"> First Middle Last </div> <div style="font-size: 1.2em; font-family: cursive;">James Nelson Bradner</div>				2a DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month Day Year </div> <div style="font-size: 1.2em; font-family: cursive;">May 22 1969</div>				2b HOUR <div style="font-size: 1.2em; font-family: cursive;">3:47 PM</div>			
3 SEX <div style="font-size: 1.2em; font-family: cursive;">male</div>		4 RACE <div style="font-size: 1.2em; font-family: cursive;">C</div>		5 DATE OF BIRTH <div style="font-size: 1.2em; font-family: cursive;">5-7-1894</div>		6 AGE (in years last birthday) <div style="font-size: 1.2em; font-family: cursive;">70</div>		IF UNDER 1 YEAR <div style="display: flex; justify-content: space-between;"> MONTHS DAYS </div>		IF UNDER 24 HRS <div style="display: flex; justify-content: space-between;"> HOURS MIN </div>	
7a BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em; font-family: cursive;">Md.</div>		7b. CITIZEN OF WHAT COUNTRY? <div style="font-size: 1.2em; font-family: cursive;">USA</div>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <div style="font-size: 1.2em; font-family: cursive;">Montgomery</div>					
10. CITY OR TOWN OF DEATH <div style="font-size: 1.2em; font-family: cursive;">Bethesda</div>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <div style="font-size: 1.2em; font-family: cursive;">Suburban</div>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <div style="font-size: 1.2em; font-family: cursive;">Retired-Truck Driver</div>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <div style="font-size: 1.2em; font-family: cursive;">Md</div>		13b. COUNTY <div style="font-size: 1.2em; font-family: cursive;">Montgomery</div>		13c CITY OR TOWN <div style="font-size: 1.2em; font-family: cursive;">Gaithersburg</div>		13d INSIDE CITY (If YES <input type="checkbox"/> NO <input type="checkbox"/>) <div style="font-size: 1.2em; font-family: cursive;">Gaithersburg, Md.</div>		13e STREET AND NUMBER			
14 FATHER'S NAME <div style="display: flex; justify-content: space-between;"> First Middle Last </div> <div style="font-size: 1.2em; font-family: cursive;">Howard Feather</div>				5 MOTHER'S M maiden NAME <div style="display: flex; justify-content: space-between;"> First Middle Last </div> <div style="font-size: 1.2em; font-family: cursive;">Rosie Lancaster</div>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(Yes, no, or unknown) (If yes give war or dates of service)</small> <div style="font-size: 1.2em; font-family: cursive;">No</div>				16b SOCIAL SECURITY NO <div style="font-size: 1.2em; font-family: cursive;">220-05-4384</div>		17 INFORMANT <div style="font-size: 1.2em; font-family: cursive;">Address</div>					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) <div style="border: 1px solid black; padding: 5px;"> PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema <div style="display: flex; justify-content: space-between;"> 3910 DUE TO, OR AS A CONSEQUENCE OF </div> <div style="border-left: 1px solid black; padding-left: 10px;"> (b) Acute pericarditis DUE TO, OR AS A CONSEQUENCE OF (c) </div> </div>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <div style="font-size: 1.2em; font-family: cursive;">5/16/69</div>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <div style="font-size: 1.2em; font-family: cursive;">Ca y Prostate</div>			20a. AUTOPSY? <div style="display: flex; justify-content: space-between;"> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(If either, notify medical examiner)</small>			21b. TIME OF INJURY <div style="display: flex; justify-content: space-between;"> HOUR A.M. Month Day Year </div> <div style="font-size: 1.2em; font-family: cursive;">P.M. 19</div>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED <div style="display: flex; justify-content: space-between;"> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> </div>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 5/19 1969 , to 5/22 1969 , that (I) (we) last saw the deceased alive on 5/21 1969 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <div style="font-size: 1.2em; font-family: cursive;">Richard H. Snowden MD</div>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <div style="font-size: 1.2em; font-family: cursive;">5/23/69</div>		
22d. PHYSICIAN'S NAME (Type) RICHARD H. SNOWDEN						22e. ADDRESS <div style="font-size: 1.2em; font-family: cursive;">4700 Busley Boulevard Chevy Chase Md.</div>					
23a. BURIAL OR CREMATION <div style="font-size: 1.2em; font-family: cursive;">BURIAL</div>			23b. DATE <div style="font-size: 1.2em; font-family: cursive;">5-26-69</div>			23c. NAME OF CEMETERY OR CREMATORY <div style="font-size: 1.2em; font-family: cursive;">BROOKE GROVE CEM.</div>			23d. LOCATION (City or Town) (County) (State) <div style="font-size: 1.2em; font-family: cursive;">LAYTONSVILLE, MONTG. MD</div>		
24 FUNERAL DIRECTOR <div style="font-size: 1.2em; font-family: cursive;">Robert L. Snowden</div>						ADDRESS <div style="font-size: 1.2em; font-family: cursive;">ROCKVILLE, MD</div>			25a. REC'D BY REGISTRAR 		

FOR STATE
HEALTH DEPT.

07196

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07192

1 DECEASED-NAME (Type or Print) Kevin Tyrone Pumphrey			2a DATE KNOWN OF DEATH ESTIMATED Month 5 Day 30 Year 69			2b HOUR 694:50 AM			
3 SEX M	4 RACE C	5 DATE OF BIRTH 2-22-62	6 AGE (n years last birthday) 7 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 5 Day 30 Year 69			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (if not in hosp tol give street address) Montgomery General			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) minor		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Sandy Spg.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 18514 Brooke Rd.	
14 FATHER'S NAME First Middle Last Melvin Pumphrey			15 MOTHER'S MAIDEN NAME First Middle Last Joyce Offord Pumphrey						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO (if yes give war or dates of service)		17. INFORMANT ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration & Maceration of Brain &</u> <u>15.6</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Compound Fractures of Skull</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Trauma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR AM/PM 12:01 PM 5/25/69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Rode Bike in front of car.</u>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Street</u>		21f LOCATION Street or R.F.D. No City or Town County State <u>Brooke Rd. Near Rt 28 Sandy Spring Mont. Md.</u>					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED <u>May 30, 1969</u>			
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 6/3/69		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Sandy Spring, Montg. Md.			
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE JUN 4 1969		25b. REGISTRAR'S SIGNATURE <u>William D. Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

813-6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Herman			Carle			May			11:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
male		white		February 7, 1886		8.3 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ohio		U. S. A.				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Kensington			Carroll Hall Sanitarium			Retired Clerk Merchandise			
13a. USUAL RESIDENCE (Where deceased lived if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. STREET AND NUMBER	
Maryland			Prince Georges			Hyattsville		2600 Queens Chapel Rd.	
4. FATHER'S NAME			5. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Emmett Ramey			Mame Hawkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			
no			579-20-7839			Florence Van Horn (same as 13d) Sister			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease</u>									years-
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Senile psychosis</u>									2
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
			HOUR A.M. Month Day Year						
			P.M. 19						
22a. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 32, 1969</u> , to <u>May 31, 1969</u> , that (I) (we) saw the deceased alive on <u>May 31, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Katharine A. Chapman, M.D.						June 1, 1969			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Katharine A. Chapman						3924 Baltimore St. Kensington, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Removal			6/2/69		Bloomfield Cemetery		Sparta, Ohio		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
The S.H.Hines Co. Washington, D. C.						JUN 4 1969		K. Hines	

07198

CERTIFICATE OF DEATH

07194

1. DECEASED-NAME (Type or print) <u>Burvie Oates Ramsey</u>			2a. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>69</u>			2b. HOUR <u>6 A</u> M	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>1-28-10</u>		6. AGE (In years last birthday) <u>59</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Estimator</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Estimator</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>md.</u>		13b. COUNTY <u>Montgomery</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <u>10124 Greenock Rd.</u>	
14. FATHER'S NAME First <u>Charles</u> Middle <u>James</u> Last <u>Woods</u>		15. MOTHER'S MAIDEN NAME First <u>Elizabeth</u> Middle <u>Woods</u> Last <u>Woods</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown: <u>no</u>		16b. SOCIAL SECURITY NO. <u>57-05-1175</u>		17. INFORMANT <u>Sarah Williams</u> Address <u>10124 Greenock Rd., Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 2000 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Reticular cell sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 mos</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1968</u> to <u>May 1969</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>G. Lennard Gold</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/31/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>				22e. ADDRESS <u>9801-Ga. Ave. Silver Spring, Maryland</u>			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <u>May 3, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parham Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Beltsville, Md., Md.</u>	
24. FUNERAL DIRECTOR <u>James E. Pamphrey, 8434</u> ADDRESS <u>8434</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07199

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Albert D. Reading</i>			2a DATE OF DEATH Month <i>May</i> Day <i>19</i> Year <i>1969</i>			2b HOUR <i>6:27</i> M	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>11/2/1944</i>		6 AGE (In years, months, days) <i>24</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Member Vet. Service</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Pa.</i>		13b COUNTY <i>Federal</i>		13c CITY OR TOWN <i>F.D. Box #9</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <i>John</i> Middle <i>Reading</i> Last <i>Reading</i>			15 MOTHER'S MAIDEN NAME First <i>Almeda</i> Middle <i>Ritter</i> Last <i>Ritter</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>yes</i>		16b SOCIAL SECURITY NO. <i>179-07-2234</i>		17 INFORMANT <i>Mrs. George Kimminger</i>		Address <i>1707-15th St. N.W. Bethesda, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Aneurysm, saccular, abdominal aorta, ruptured</i> <i>441.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/19</i> , 19 <i>69</i> , to <i>5/19</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/19</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Robert C. Daddario</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/20/69</i>	
22d PHYSICIAN'S NAME (Type) <i>ROBERT C. DADDARIO</i>				22e ADDRESS <i>5413 CEDAR LANE BETHESDA MD</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>5/23/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Hillside</i>		23d LOCATION (City or Town) (County) (State) <i>Roslyn, Pennsylvania</i>	
24 FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</i>				25a REC'D BY REGISTRAR <i>MAY 22 1969</i>		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

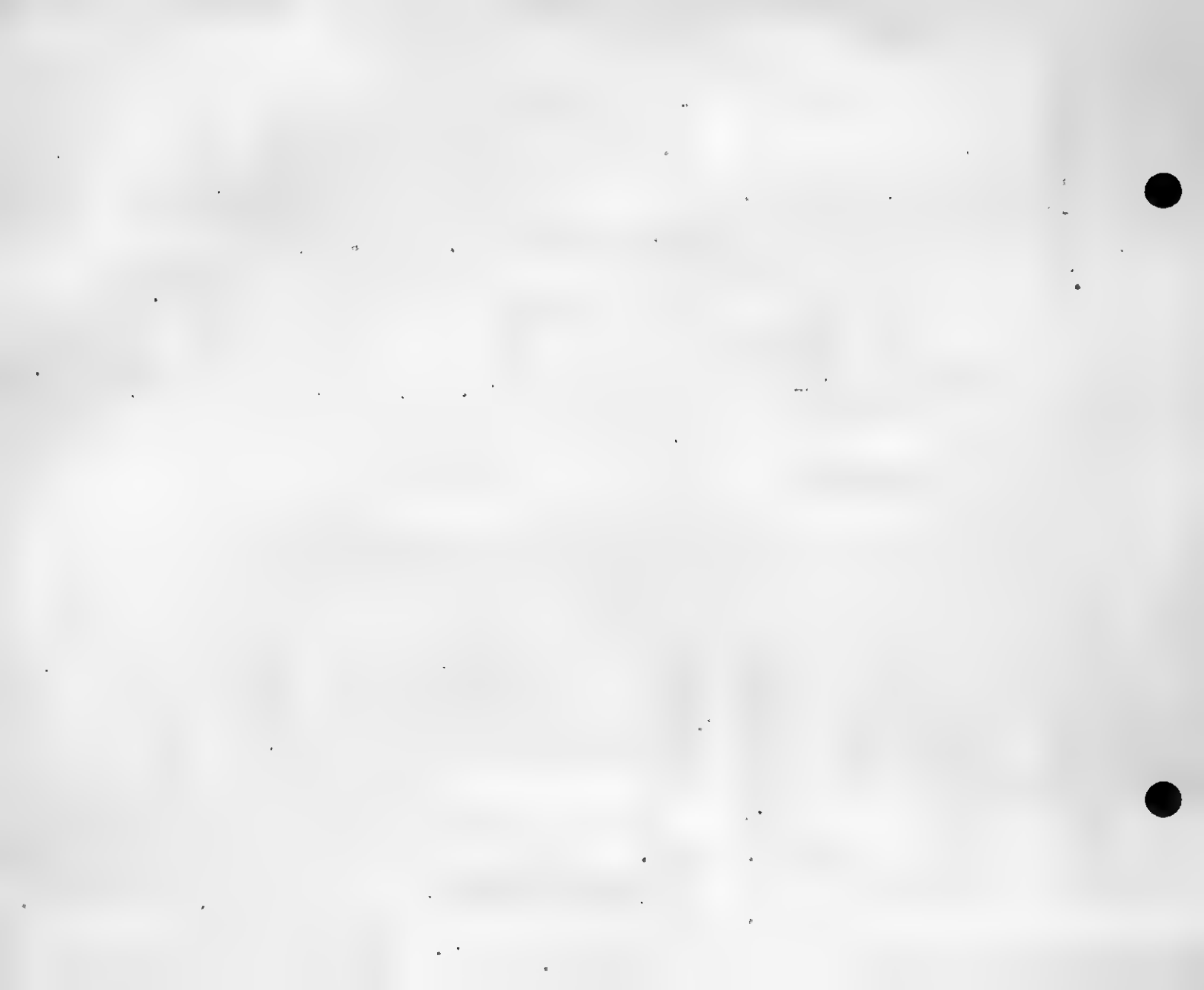
Items 18-21 of the Division of Vital Records, 301 W. Preston Street, Baltimore, Maryland 21201

07200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07196

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR	
GERALD VINCENT REYNOLDS								MAY 20 1969								09:10 AM	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		Month		Day		Year	
MALE	CAUC	19 SEPT. 1906		62 YRS						MAY 20 1969						9:10 AM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D.VORCED <input type="checkbox"/>		9. COUNTY OF DEATH										Md	
NEW YORK		USA				MONTGOMERY											
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY											
BETHESDA		BETHESDA NAVAL HOSP.		US NAVY													
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER									
VIRGINIA				FALLS CHURCH				305 WALNUT ST.									
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
JOHN REYNOLDS								Margaret Reilly									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give year or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS									
YES		1940-1960				MISS. SUSAN REYNOLDS		8220 TORY RD.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Primary</u> Laennec's cirrhosis of liver with DUE TO, OR AS A CONSEQUENCE OF hepatic failure (b) <u>Chronic alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		4 days											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		Fracture of left femur															
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 6:00 PM 5/16 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fall at home causing fracture of left hip													
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No City or Town County State 305 Walnut St. Falls Church Va.													
22a I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		John G. Ball		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MED CAL EXAMINER <input type="checkbox"/>		DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED May 20, 1969					
EXAMINER'S NAME (Type)		JOHN G. BALL MD.				ADDRESS (Street, city, town, or county)											
23a B. RIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)											
Burial		May 22, 1969		ARLINGTON NATIONAL CEMETERY		ARLINGTON, ARLINGTON, VA.											
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D By REGISTRAR		25b REGISTRAR'S SIGNATURE											
ARLINGTON FUNERAL HOME		3901 NORTH FAIRFAX DR. ARLINGTON, VA.		DATE MAY 26 1969		Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

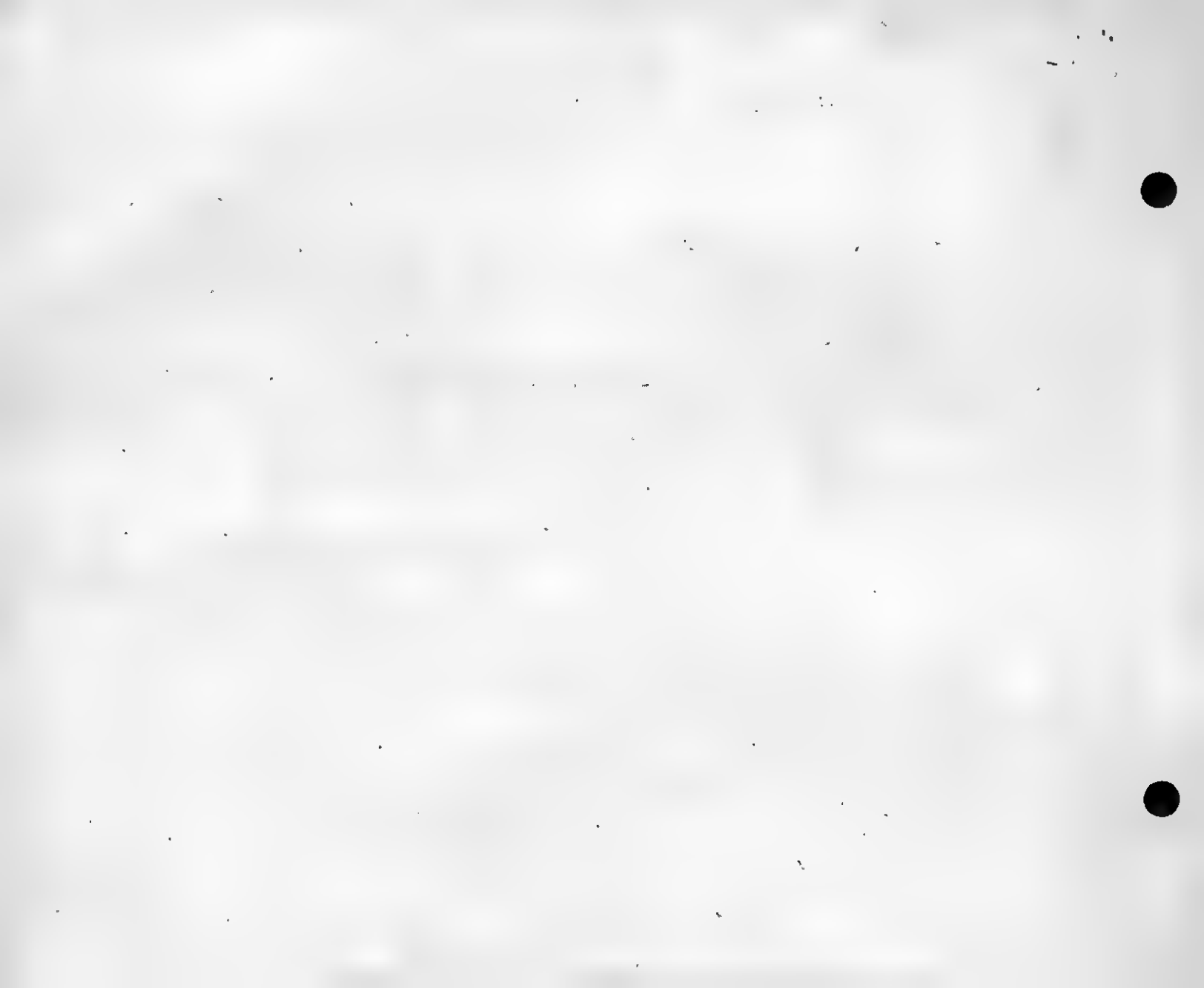
07201

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07197

1. DECEASED-NAME (Type or print) <u>Aubrey G. Richmond</u>			2a. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1969</u>			2b. HOUR <u>6:15</u> A.M.	
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>DEC. 1, 1904</u>		6. AGE (in years last birthday) <u>94</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>MISS.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md.	
10. CITY OR TOWN OF DEATH <u>BETHESDA</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WESTWOOD N.H.</u>		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) <u>RET.-CIVIL SERVANT</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <u>MD.</u>		13b. COUNTY <u>MONTG.</u>		13c. CITY OR TOWN <u>BETHESDA</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>4605 HIGH ST.</u>		14. FATHER'S NAME First <u>UNKNOWN</u> Middle <u>UNKNOWN</u> Last <u>UNKNOWN</u>		15. MOTHER'S MAIDEN NAME First <u>UNKNOWN</u> Middle <u>UNKNOWN</u> Last <u>UNKNOWN</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>26-46-0214</u>		17. INFORMANT <u>FORREST GRIMES-4021 ALTON PL. N.W. WASH., D.C.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis myocardial ischemia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>1 hr.</u> <u>2 yrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , to <u>5/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/2</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S.A. Thomas MD</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/3/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>S.A. Thomas MD.</u>		22e. ADDRESS <u>4301 48th St N.W. Wash. DC.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5/6/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MD.</u>	
24. FUNERAL DIRECTOR <u>TOS. GAWLER'S SONS</u>		ADDRESS <u>5130 WIS AVEN. N.W. WASHINGTON, D.C.</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Yodanis</u>	



1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07202

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07198

1. DECEASED NAME (Type or print) First Middle Last <i>Therese S. Ricketts</i>			2a. DATE OF DEATH Month Day Year <i>May 29 1969</i>			2b. HOUR Min <i>12</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>4/11/12</i>		6. AGE (In years last birthday) <i>57</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Hubert Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Supervisor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Therese</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>15861 - Ridland Rd.</i>		14. FATHER'S NAME First Middle Last <i>Alfred Ritter</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Gertrude Hoge</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>760</i>		17. INFORMANT <i>Francis Ricketts</i>		Address <i>3 Stone Rd. Stone</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchio pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF <i>gen. metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <i>1-14-69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exst. Thymus gland</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-14</i> , 19 <i>69</i> to <i>5-24</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-24</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>V.C. DeGuzman</i>				22c. DATE SIGNED <i>May 29, 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>V.C. DEGUZMAN</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/2/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lukes Church Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Derwood Montg. Md.</i>	
24. FUNERAL DIRECTOR <i>1331 Rockville Pike</i> <i>TYSON WHEELER FUNERAL HOME Rockville, Md.</i>				25a. REC'D BY REGISTRAR <i>JUN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07203

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07199

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Edwina B. Kicketts			2a. DATE OF DEATH Month May Day 6 Year 1969			2b. HOUR 7:30 AM								
3 SEX Female		4 RACE White		5 DATE OF BIRTH 9/22/02		6 AGE (in years last birthday) 66 YRS.		7 UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0				
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (if not in hosp tal give street address) Suburban			2a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) none			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.			13b. COUNTY Mont.			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5400 - Park Hill Rd		
4 FATHER'S NAME First John Middle Edgar Last Benson			15. MOTHER'S MAIDEN NAME First Jessie Middle Lovell Last Lovell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown no			16b. SOCIAL SECURITY NO 216-12-4172			17 INFORMANT Dr. Donald Kicketts Address 5024 9608 Rock		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY 4311 IMMEDIATE CAUSE (a) Hemorrhage, intracerebral (rt. temporo-occipital) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY) OFFICE BUILDING ETC			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____								
22a. I certify that (I) (th's hospital) attended the deceased from 4/29 , 19 69 , to 5/6 , 19 69 , that (I) (we) last saw the deceased alive on 5/6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death														
22b. SIGNATURE Joseph F. Schanno						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED May 6 1969					
22d. PHYSICIAN'S NAME (Type) JOSEPH F. SCHANNO						22e. ADDRESS 8218 Shuman Ave. Bethesda								
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial			23b. DATE 5-8-69			23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville, Maryland					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR MAY 12 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07204

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07200

1 DECEASED NAME (Type or print) Elizabeth Ann Rinker			2a DATE OF DEATH Month May Day 15 Year 1969			2b HOUR 8:10 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10 May 1945		6 AGE (in years last birthday) 24 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a USUA. OCCUPAT OH (Kind of work done during most of working life, even if retired.) Housewife			12b KIND OF BUSINESS OR INDUSTRY Home	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland			13b COUNTY Prince Georges		13c CITY OR TOWN Greenbelt		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7 L Research Road	
14. FATHER'S NAME First William Middle Seibel Last Seibel			15 MOTHER'S MAIDEN NAME First Virginia Middle Medley Last Medley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b SOCIAL SECURITY NO. 213-42-5487		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Myelogenous Leukemia/ in blastic crisis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 6-10 hours 3 1/2 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Probable Hepatitis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 22 February, 1969 , to 15 May, 1969 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 15 May 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.										
22b. SIGNATURE David A. Bray MD					DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 May 1969	
22d. PHYSICIAN'S NAME (Type) David A. Bray, MD					22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/18/69		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d LOCATION (City or Town) (County) (State) Burtonsville Md				
24 FUNERAL DIRECTOR Nanaclean Funeral Home, Laurel, Md					25a. REC'D BY REGISTRAR DATE MAY 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07205									
07201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Hedwig</i>			First <i>L.</i> Middle <i>G.</i> Last <i>Roberts</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>6</i> Year <i>1969</i>			2b. HOUR <i>6:15</i> M
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>9-21-1888</i>		6 AGE (in years last birthday) <i>80</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN	
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Bethesda House 194 Rollins Ave</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>BATCHLER</i> Last <i>UNKNOWN</i>			15. MOTHER'S MAIDEN NAME First <i>UNKNOWN</i> Middle <i>UNKNOWN</i> Last <i>UNKNOWN</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates at service) <i>No</i>			
16b. SOCIAL SECURITY NO <i>101-10-1010</i>			17. INFORMANT <i>Son - DANIEL W. ROBERTS</i>			Address <i>ARLINGTON, VA 717-NORTH Edison ST</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>rupt. abdominal aortic aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>10 yrs</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>May</i> Day <i>5</i> Year <i>1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) <i>10111 IN WYOMING RD.</i>		21f. LOCATION Street or R.F.D. No. <i>780' Norfolk Ave.</i> City or Town <i>Bethesda</i> County <i>Montgomery</i> State <i>MD</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 1967, to <i>6 May</i> , 1969, that (I) (we) last saw the deceased alive on <i>5 May</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John W. Roberts</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>5 6 69</i>			
22d. PHYSICIAN'S NAME (Type) <i>John W. Roberts</i>		22e. ADDRESS <i>780' Norfolk Ave., Bethesda, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-8-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland, Md</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Simmons Bros</i>		ADDRESS <i>Wash. DC</i>		25a. REC'D BY REGISTRAR <i>MAY 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Robert J. Jones</i>			
26. FUNERAL HOME <i>Simmons Bros 1661 Good Hope Rd SE</i>									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 412 Maryland State Department of Health
7-22-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07208

1. DECEASED-NAME (Type or Print) <u>Weller</u> <u>Louis</u> <u>Roberts</u>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <u>5</u> Day <u>2</u> Year <u>69</u>		2b. HOUR <u>10:55A</u>
3 SEX <u>Male</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>Mar. 1, 1916</u>	6 AGE (in years and birthday) <u>53</u> YRS	7 UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>
7a BIRTHPLACE (State or foreign country) <u>Va.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Montgomery</u>
10 CITY OR TOWN OF DEATH <u>Takoma Pk</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>7701 Eastern Ave #204</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u> </u>
13a USUAL RESIDENCE (Where deceased lived, if not institution residence before admission) STATE <u>Maryland</u>		13b COUNTY <u>Montgomery</u>	13c CITY OR TOWN <u>Takoma Pk</u>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME <u>John</u> <u>Roberts</u>		15 MOTHER'S MAIDEN NAME <u>Beulah</u> <u>Watson</u>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>
16b SOCIAL SECURITY NO. <u>578-20-8399</u>		17 INFORMANT <u>Pearl Selba (Sister)</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobar pneumonia, right lung</u> <u>571.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u> </u>				
19a. DATE OF OPERATION <u> </u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u> </u>		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u> </u>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u> </u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u> </u>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u> </u>		21f. LOCATION Street or RFD No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>MAY 2, 1969</u>
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE <u>May 5, 1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Baptist</u>		23d. LOCATION (City or Town) (County) (State) <u>Ruckersville, Va.</u>
24 FUNERAL DIRECTOR <u>Everly Wheatley</u>		25a REC'D BY REG STRAR DATE <u>MAY 7 1969</u>		25b REGISTRAR'S SIGNATURE <u>Richard D. ...</u>



CERTIFICATE OF DEATH

07207

07203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove author papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print) Jennie Robinson			2a. DATE OF DEATH 5 Month 9 Day '69			2b. HOUR 9:55 AM					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 10-20-75		6. AGE (In years last birthday) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Baltimore Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md					
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rockville Valley Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life) Domestic			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE District of Columbia			13b. CITY OR TOWN Washington		13c. SIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 434 R. Island Ave N.W.			13e. CITY AND STATE Washington D.C.	
14. FATHER'S NAME First Middle Last CHARLES BUCHANAN			15. MOTHER'S MAIDEN NAME First Middle Last ISABELLA ROBINSON-SON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No			16b. SOCIAL SECURITY NO 130			17. INFORMANT ISABELLA ROBINSON-SON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4117 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Thrombophlebitis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 15 YRS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Thrombophlebitis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 4/21/69 to 5/9/69 , that (I) (we) last saw the deceased alive on 5/7/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Henry C. Services MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/9/69		
22d. PHYSICIAN'S NAME (Type) Henry C. Services MD						22e. ADDRESS 5443 Cedar Lane Bethesda Md					
23a. BURIAL CREMATION, etc. Buried			23b. DATE 5/14/1969			23c. NAME OF CEMETERY OR CREMATORY Harmony MEM CEM			23d. LOCATION (City or Town) (County) (State) Landover Md		
24. FUNERAL DIRECTOR William Spangler						25. REC'D BY REGISTRAR Wash, D.C.			25b. REGISTRAR'S SIGNATURE May 13 1969		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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07208

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07204

1 DECEASED NAME (Type or Print) LULA MAY ROYSTON			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 5 - 17 Year 1969			2b HOUR 2:30 P.M.
3 SEX Fe	4 RACE Cauc	5 DATE OF BIRTH 8/12/85	6 AGE (In years) 83 YRS.	7 UNDER 1 YEAR MONTHS 0 DAYS 0	8 UNDER 24 HRS HOURS 0 MIN. 0	2c DATE PRONOUNCED DEAD Month 5 - 17 - Year 1969
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 COUNTY OF DEATH Montgomery		9a CITY OR TOWN OF DEATH Burtonsville				
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3929 Sandy Spring Rd.		12a USUAL OCCUPATION (K not work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY None		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD		13b COUNTY Montg.		13c CITY OR TOWN Burtonsville		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
13e STREET AND NUMBER 3929 SANDY SPRING RD.						
14 FATHER'S NAME James Royston			15 MOTHER'S MAIDEN NAME Ellen Libbert			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. 3929		17 INFORMANT Mrs. Louise Reed - above		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency						
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease						
DUE TO, OR AS A CONSEQUENCE OF (c) 						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 						
19a DATE OF OPERATION 		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 			20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 		21b TIME OF INJURY Month, Day, Year 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f LOCATION: Street or R.F.D. No City or Town County State 		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED MAY 17, 1969		
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/20/69		23c NAME OF CEMETERY OR CREMATORY Ft. Detweiler Cem.		23d LOCATION (City or Town) Calmar Manor Md (County) (State)
24 FUNERAL DIRECTOR Canadaan Funeral Home, Laurel		ADDRESS 		25a REC'D BY REGISTRAR 		25b REGISTRAR'S SIGNATURE Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Emma			A. Ruebsam			Month Day Year 5 31 69			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		Unknown		81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Canada		Unknown USA				Montgomery County Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Kensington		Carroll Hall Nursing				Housewife		Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Wash. DC							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5415 Conn., Ave., N.W.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Samuel Wegenast			Martha Bowman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			Unknown		Sister 5415 Conn Ave., N.W., Wash., D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>63</u> , to <u>30 May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>29 May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John H. Wynman</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>5-31-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>JOHN H. WYMAN</u>					22e. ADDRESS <u>7611 NORRIS AVE. Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		5/31/69		Cedar Hill Crematory		Suitland, P.G. Co., Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
R.A. Pumphrey 7557 Wisc. Ave.					Bethesda, Md.		J. Charles Judge		

191579

07210

07206

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GRACE			First Middle Last Campbell Russell			2a. DATE OF DEATH Month Day Year 5 5 69			2b. HOUR 6:50 A M		
3. SEX FEMALE			4. RACE CAU.			5. DATE OF BIRTH 9/9/88			6. AGE (In years last birthday) 80 YRS.		
7a. BIRTHPLACE (State or foreign country) ENGLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRESDENOR LANE NURSING & CONVALESCENT CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.			13b. COUNTY DISTRICT OF COLUMBIA			13c. CITY OR TOWN WASHINGTON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 2200 - 19th ST N.W.			14. FATHER'S NAME First Middle Last William C. LIDSTONE			15. MOTHER'S MAIDEN NAME First Middle Last SELEMA AUGUSTA CAMPBELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No			16b. SOCIAL SECURITY NO. 220-44-8242			17. INFORMANT Son William Russell			Address Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH CAUSED BY:											
IMMEDIATE CAUSE (a) Intestinal obstruction											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Tumor of intestinal tract.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Hat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/3, 1969 , to present , that (I) (we) last saw the deceased alive on 5/4, 1969 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John B. Umhau						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5/5/69		
22d. PHYSICIAN'S NAME (Type) JOHN B. UMHOU						22e. ADDRESS 8805 Conn. Ave. Chevy Chase Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5-8-69			23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.			23d. LOCATION (City or Town) (County) (State) Washington, D. C.		
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland						25a. REC'D BY REGISTRAR DATE MAY 7 1969			25b. REGISTRAR'S SIGNATURE William J. Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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